# DELAWARE HEALTH AND SOCIAL SERVICES
# DIVISION OF MEDICAID AND MEDICAL ASSISTANCE
# STATE MEDICAID HIT PLAN (SMHP)

11/20/2018

Version 6.3

# REVISION HISTORY

| Version Number | Date | Reviewer | Comments |
|---|---|---|---|
| 1.0 | 2/28/2011 | FOX | Initial Draft |
| 2.0 | 3/10/2011 | FOX | First Version- State Review |
| 2.1 | 4/13/2011 | FOX | For QA Review |
| 3.0 | 5/5/2011 | State | Feedback Received from the State |
| 4.0 | 5/11/2011 | State | Final-For Submission to CMS |
| 5.0 | 9/9/2011 | State | Response to CMS Comments – For Re-submission to CMS |
| 6.0 | 12/21/2012 | Willa Langdon | Amendment for Stage I Meaningful Use policy changes |
| 6.1 | 10/30/2013 | Willa Langdon<br>Mary E. Marinari | MU updates added; SMHP updated for current information. See CC sections 14 and 15 below for redlined detail of sections changed. |
| 6.2 | 04/10/2017 | Christene Ramsay<br>Mary E. Marinari | Revisions to sections of the SMHP are redlined. |
| 6.3 | 011/16/2018 | Christene Ramsay<br>Mary E. Marinari | Revisions to sections of the SMHP are redlined. |

## Change Control Document

| Issue# | SMHP Updates | Section | Location |
|---|---|---|---|
| | **PATIENT VOLUME** | | |
| **1** | **Practicing Predominately Calculations:**<br><br>If patient volume is between 20 percent and 30 percent, a health professional that seeks to use the pediatrician volume should have a pediatrician or neonatology taxonomy. Currently a provider that seeks to use the pediatrician volume but does not have pediatrician taxonomy should be denied. DMMA will require all pediatricians to provide proof of license. If a physician assistant applicant practices predominantly in an FQHC/RHC, the applicant completes a patient volume table that includes counts of needy individuals as well as locations, numerator, and denominator. If the physician assistant applicant does not practice predominantly in an FQHC/RHC, the provider completes a separate patient volume table with locations, numerator, and denominator. The system calculates patient volumes and suspends applications that do not meet the patient volume requirements. EPs may use a six-month period within the prior calendar year or preceding 12 month period from the date of attestation for the definition of practicing predominantly (more than 50% of the encounters). | 4.9.1.1 Patient Volume Determination | Page 88 |

| Issue# | SMHP Updates | Section | Location |
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| 2 | **Medicaid Enrolled Encounters:**<br>Volume thresholds are calculated using as the numerator the hospital's or EP's total number of Medicaid member encounters for the 90-day period to include service rendered on any one day to a Medicaid-enrolled individual, regardless of payment liability (this includes zero paid claims) and the denominator as all patient encounters for the same EP or hospital over the same 90-day period. Per CMS, CHIP beneficiaries cannot be included in the patient volume. Since Delaware physicians are unable to differentiate between CHIP and Medicaid patients, EPs will report a combined total. Any provider that appears eligible will have their actual CHIP encounter volume extracted from MMIS claim data and deducted from the provider reported volume by DMMA after application submission. The new calculated volume will be compared to the Medicaid volume on record. On average, CHIP contributes about two percent to the total claim volume and is three percent of DMMA's client volume | 4.9.3 Patient Volume Calculation | Page 91 |
| 3 | **CHIP Encounters:**<br>Per CMS 495.306, CHIP encounters cannot be included in the patient volume if CHIP is a stand-alone Title XXII program. | 4.9.3 Patient Volume Calculation | Page 91 |
| 4 | **Panel Methodology:**<br>We do not currently use panel volume. Per Stage 2 the time period between encounters with a patient is now 24 months and can be included if DE should begin to use panel volume. This is a change from 12 to 24 months to account for new clinical guidelines from the U.S. Preventive health Services Task Force that allow greater spacing between some wellness visits. | 4.9.3 Patient Volume Calculation | Page 92 |

| Issue# | SMHP **Updates** | Section | Location |
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| **5** | **Provider, Panel and Needy Individual Patient Volume:**<br>[Total (Medicaid) patient encounters in any consecutive 90-day period within the prior CY –Total CHIP encounters in that same 90-day period/Total patient encounters in that same 90-day period or preceding 12 month period from the date of the attestation] * 100 | 4.9.5 Patient Volume Calculation | Page 93 |
| **EXEMPTION FROM HOSPITAL BASED EXCLUSION FOR EPS** | | | |
| **6** | **Hospital Based Exclusion:**<br>EPs who can demonstrate that the EP funds the acquisition, implementation, and maintenance of Certified EHR Technology, including supporting hardware and any interfaces necessary to meet meaningful use without reimbursement from an eligible hospital or CAH; and uses such Certified EHR Technology in the inpatient or emergency department of a hospital (instead of the hospital's CEHRT) are now eligible for EHR Incentive Payments. | **4.5.9** Assuring Providers Are Not Hospital-Based | Page 93 |
| **HOSPITAL CHANGES** | | | |
| **7** | **Hospitals Switching States:**<br>Hospitals choosing to change from the state originating the previous EHR incentive payment(s) may do so provided that both Delaware EHR Incentive Payment Program and the selected transfer state have consulted with and have received the approval from CMS. | 4.12.2 EH Payment Calculation | Page 98 |

| Issue# | SMHP **Updates** | Section | Location |
|---|---|---|---|
| **8** | **Dual eligible Hospital Audits and Appeals:**<br><br>For dually eligible hospitals and the children's hospital, the State will perform audits and appeals of eligibility criteria and allow CMS Medicare to audit for Meaningful Use and conduct appeals to Meaningful Use. Additionally, the State agrees to be bound by the audit and appeal findings of CMS; perform any necessary recoupments arising from the audits; and be liable for any FFP granted the state to pay eligible hospitals that, upon audit, and any subsequent appeal, are determined not to have been meaningful EHR users. | Appendix C to the SMHP<br><br>3.0 Risk Assessment | Page 10 |

| Issue# | SMHP **Updates** | **Section** | **Location** |
|---|---|---|---|
| **STAGE 1 MU MEASURES** | | | |
| **9** | **Stage 1 MU Measures:**<br>Stage 1 MU Measures 2013 changes: Core & Menu measures will be incorporated as part of the below from the SMHP.<br>"The DMMA QMS currently incorporates a list of mandatory HEDIS measures to be reported annually by the MCOs. The relevant MU measures will be incorporated into this strategy in the future and should greatly improve the monitoring of access, care delivery, health management, and care expenditures."<br>Stage 1 MU Measures (Core/Menu): *(List of MU Measures follows this section.)*<br>MAPIR 5.0 (ready spring 2013 and implemented summer/fall 2013) addresses changes to the Core Measures and Menu Set for 2013. | 4.20 Clinical Quality Data | Page 109 - 110 |
| **ADDITIONAL UPDATES** | | | |
| **10** | Changed SMHP 4.6 from "DMMA is aware of the Seven Standards and Conditions in 42 CFR Part 433" to "DMMA is aware of the Seven Standards and Conditions in Sections 1903(a)(3)(A)(i) and 1903(a)(3)(B) of the Social Security Act." | 4.7 MAPIR Overview | Page 72 |

| Issue# | SMHP **Updates** | Section | Location |
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| **11** | Provider/Hospital attestation tail.<br><br>Delaware allows EPs a grace period at the end of the calendar year of 60 days (January 1 – February 28/29) and EHs a grace period at the end of the Federal Fiscal Year of 120 days (October 1 – December 31). | 4.9 Provider Eligibility Determination | Page 88 |
| **12** | Please describe the State's ability to reconcile the appropriate Federal Financial Participation (FFP) for any recouped funds.<br><br>The identified overpayment will be returned to CMS within the 1-year Federal period. The repayment will occur, with or without the recovery having been completed by the State. Delaware will report to CMS on the CMS-64 on recoupments through established accounts receivable records that indicate the Medicaid EHR Incentive Program fund code. In the report, the State will indicate whether the funds were recovered from the provider, or if they are still outstanding. (Section 4.12.1 DHSS, DMMA, SMHP) | Appendix C to the SMHP<br><br>4.3 Post-Payment On-Site Review | Page 27 |

| Issue# | SMHP **Updates** | Section | Location |
|---|---|---|---|
| **13** | With regard to reviewing for duplicate payments, the State should also specifically ensure that eligible professionals (EPs) attesting together using the group patient volume proxy are not also receiving erroneous payments as individual EPs.<br><br>EPs Practice Locations and Affiliated Groups Verification:<br><br>1.8 Obtain and review documentation supporting the EP's practice locations by reviewing claims/encounter data in MMIS<br><br>1.9 Review the NLR/SLR to determine if any EPs within the Group attested as part of multiple Groups<br><br>Duplicate Patient Encounters Verification:<br><br>1.10 Obtain the patient volume calculations for the EP from the pre-payment audit work papers and any supporting documentation submitted by the EP to substantiate their patient volume attestation<br><br>1.11 Obtain all of the practice locations where the EPs attested as part of a group and obtain the EPs patient encounters reported as part of those groups and confirm that the patient encounters reported in the patient volume calculations were not duplicated<br><br>If the EP has duplicated its patient encounters in its patient volume calculations and the corrected calculation does not meet the patient volume threshold, the EP is not eligible. | Appendix C to the SMHP<br><br>4.0 Post Payment Desk Review and On-Site Audit Scope | Page 21 |

| Issue# | SMHP Updates | Section | Location |
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| **14** | MU<br>o Provider meets requirements for adoption, implementation, or upgrade for year one<br>o Provider meets Stage 1 MU criteria in year two<br>o Provider meets Stage 1 MU criteria established in Stage 2 Final Rule<br>o Provider meets Stage 2 MU criteria in 2014<br>o In subsequent years, provider meets the criteria established for the appropriate stage of MU | 5.2 Incentive Program Audit Process | Page 113 |

| Issue# | SMHP Updates | Section | Location |
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| **15** | Appendix C of the SMHP was updated to include updates to 6.0, Letter Forms. 6.5.2 Post Payment Review Findings and Appeal Process form letter was added. Form letters 6.1 – 6.3.2 were updated to show Calendar Year and Patient Volume Period in the subject line. Form letters 6.4 – 6.5.1 were updated to show only the Calendar Year in the subject line. | Appendix C of the SMHP. Sections 6.0 – 6.5.2 | Page 33 |
| **16** | The Flexibility Rule – effective for Program Year 2014 only | 5.2 Incentive Program Audit Process | Page 111 - 114 |
| **17** | Updated section 2.5 Environmental As is Scan to include current information on the "Testing" State Innovation Model (SIM) grant received in December 2014. | 2..5 Environmental As Is Scan | Page 42 – 43 |
| **18** | Identify the date range of the last assessment for data and separate the information by provider type. | 1..1.3 Provider EHR Incentive Program Implementation | Page 28 – 29 |
| **19** | Supply current Broadband information. The information is outdated back to 2009 and 2010. Please give an update on what these grant funds have been used for-current status. Provide an updated broadband availability map. | 2..5.2 Broadband Internet Access | Page 68 – 70 |
| **20** | Detail how Delaware will get from the as-is to the to-be phase of connecting the Veterans Administration EHRs to be accessible through HIE. | 3..1.8 Veterans Medical Centers | Page 82 |

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|---|---|---|---|
| **21** | Provide additional specificity around the stakeholder's rolls and involvement in HIT/E activities. | 4..1.2 Key Stakeholders | Page 94 – 100 |
| **22** | Discuss significant crossing of state lines for accessing health care services by Medicaid beneficiaries. | HIT/HIE Activities Crossing State Boundaries | Page 101 |

# TABLE OF CONTENTS

# LIST OF FIGURES AND TABLES

# LIST OF ACRONYMS

The following acronyms are used throughout this document:

| Acronym | Definition |
|---|---|
| A&I | Division of Audits and Investigations |
| ACH | Acute Care Hospital |
| ADA | American Dental Association |
| ADT | Admit, Discharge, Transfer |
| AG | Attorney General |
| AHEC | Area Health Education Center |
| AIDS | Acquired Immunodeficiency Syndrome |
| A/I/U | Adopt/Implement/Upgrade |
| Ai | Audacious Inquiry |
| ANSI | American National Standards Institute |
| AR | Accounts Receivable |
| ARMS | Audit and Recovery Management Services |
| ARRA | American Recovery and Reinvestment Act of 2009 |
| ASC | Accredited Standards Committee |
| ASP | Active Server Pages |
| BES | Business Exchange Services |
| BMI | Body Mass Index |
| CAH | Critical Access Hospital |
| CCD | Continuity of Care Document |
| CCHS | Christiana Care Health System |
| CCIS | Clinical Care Information System |
| CCN | CMS Certification Number |
| CDC | Centers for Disease Control and Prevention |
| CFR | Code of Federal Regulations |
| CHIP | Children's Health Insurance Program |
| CHPL | CMS Certified HIT Product List |
| CIO | Chief Information Officer |
| CMHS | Center for Mental Health Services |
| CMPI | Community Master Patient Index (see MPI) |
| CMM | Capability Maturity Module |
| CMS | Centers for Medicare & Medicaid Services |
| CNM | Certified Nurse Midwife |
| COBOL | Common Business Oriented Language |
| COLD | Computer Output to Laser Disk |
| COO | Chief Operating Officer |
| COS | Category of Service |

| | |
|---|---|
| CPOE | Computerized Provider Order Entry |
| CPAS | Claims Processing Assessment System |
| CRDP | Chronic Renal Disease Program |
| CSAT | Center for Substance Abuse Treatment |
| CT | Computed Tomography (CAT scan) |
| CY | Calendar Year |
| DAFP | Delaware Academy of Family Physicians |
| DCIS | Delaware Client Information System |
| DCMHS | Division of Child Mental Health Services |
| DCSE | Division of Child Support Enforcement |
| DDDS | Division of Developmental Disabilities Services |
| DMES | Delaware Medicaid Enterprise System |
| DERSS | Delaware Electronic Reporting and Surveillance System |
| DHCA | Delaware Health Care Association |
| DHCC | Delaware Health Care Commission |
| DHCFA | Delaware Health Care Facilities Association |
| DHCP | Delaware Healthy Children Program |
| DHEC | Delaware Higher Education Commission |
| DHHS | Department of Health and Human Services |
| DHIN | Delaware Health Information Network |
| DHSS | Department of Health and Social Services |
| DIMER | Delaware Institute of Medical Education and Research |
| DMAP | Delaware Medical Assistance Program |
| DMES | Delaware Medicaid Enterprise System |
| DMGMA | Delaware Medical Group Management Association |
| DMMA | Division of Medicaid and Medical Assistance |
| DMS | Division of Management Services |
| DOC | Department of Corrections |
| DoD | Department of Defense |
| DOQ-IT | Doctor's Office Quality – Information Technology |
| DPAP | Delaware Prescription Assistance Program |
| | |
| DPH | Division of Public Health |
| DSAMH | Division of Substance Abuse and Mental Health |
| DSCYF | Department of Services for Children, Youth, and Families |

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|---|---|
| DSHP | Diamond State Health Plan |
| DSP | Diamond State Partners |
| DSS | Division of Social Services |
| DTI | Department of Technology and Information |
| DUR | Drug Utilization Review |
| DW | Data Warehouse |
| DXC | New Corporate name for HPES as of 4/17 |
| ECMS | Electronic Commerce Management Service |
| ED | Emergency Departments (Hospital) |
| EDS | Electronic Data Systems |
| EFT | Electronic Funds Transfer |
| EH | Eligible Hospital |
| EHR | Electronic Health Record |
| ELC | Epidemiology and Laboratory Capacity |
| EMR | Electronic Medical Record |
| EMS | Emergency Management System |
| EP | Eligible Professional |
| EPLS | Excluded Parties List System |
| EPSDT | Early Periodic Screening, Diagnosis, and Treatment |
| ER | Emergency Room |
| EVRS | Electronic Vital Records System |
| EVS | Electronic Verification System |
| eCQM | Electronic Clinical Quality Measures |
| EPx | Electronic Prescribing |
| FA | Fiscal Agent |
| FACTS | Family and Children's Tracking System |
| FAQs | Frequently Asked Questions |
| FFP | Federal Financial Participation |
| FFS | Fee-For-Service |
| FFY | Federal Fiscal Year |
| FOIA | Freedom of Information Act |
| FOX | Fox Systems, a Cognosante company |
| FPL | Federal Poverty Level |
| FQHC | Federally Qualified Health Center |
| FY | Fiscal Year |
| FTP | File Transfer Protocol |
| GE | General Electric |
| HCBS | Home and Community Based Services |
| HEDIS | Healthcare Effectiveness Data and Information Set |
| HHS | United States Department of Health and |

| | |
|---|---|
| | Human Services |
| HIE | Health Information Exchange |
| HIPAA | Health Insurance Portability and Accountability Act |
| HIT | Health Information Technology |
| HITSP | Healthcare Information Technology Standards Panel |
| HITECH | Health Information Technology for Economic and Clinical Health |
| HIV | Human Immunodeficiency Virus |
| HL7 | Health Level Seven |
| HMS | Health Management Systems |
| HPE | Hewlett Packard Enterprise Services |
| HRSA | Health Resources and Services Administration |
| HTTPS | Hypertext Transfer Protocol Secure |
| IAPD | Implementation Advance Planning Document |
| IBM | International Business Machines |
| ICD-10 | International Classification of Diseases, Version 10 |
| ID | Identification |
| IHS | Indian Health Services |
| IPA | Institute for Public Administration |
| IR | Implementation Roadmap |
| IRM | Information Resource Management |
| ISIS | Integrated Services Information System |
| ISU | Information System Unit |
| IT | Information Technology |
| JCAHO | Joint Commission on Accreditation of Healthcare Organizations |
| LAN | Local Area Network |
| LIMS | Laboratory Information Management System |
| LTC | Long-Term Care |
| MAPIR | Medical Assistance Provider Incentive Repository |
| MAR | Management and Administrative Reporting |
| MCBR | Medicaid Credit Balance Report |
| MCI | Master Client Index |
| MCO | Managed Care Organization |
| MDS | Minimum Data Set |
| MFCU | Medicaid Fraud Control Unit |

| | |
|---|---|
| MGMA | Medical Group Management Association |
| MHSIP | Mental Health Statistics Improvement Program |
| MITA | Medicaid Information Technology Architecture |
| MMDS | Medical Management and Delegated Services |
| MMIS | Medicaid Management Information System |
| MML | MITA Maturity Level |
| MOU | Memorandum of Understanding |
| MPI | Master Patient/Person Index |
| MRI | Magnetic Resonance Imaging |
| MS | Microsoft |
| MSD | Medical Society of Delaware |
| MSIS | Medicaid Statistical Information Statistics |
| MTG | Medicaid Transformation Grant |
| MU | Meaningful Use |
| NACDS | National Association of Chain Drug Stores |
| NCPDP | National Council for Prescription Drug Programs |
| NDC | National Drug Code |
| NET | Non-Emergency Transportation |
| NHIE | National Health Information Exchange |
| NHIN | Nationwide Health Information Network |
| NOMS | National Outcome Measures |
| NPI | National Provider Identifier |
| NPPES | National Plan and Provider Enumeration System |
| NPRM | National Proposed Rule Making |
| NTIA | National Telecommunications and Information Administration |
| OATS | Office of Administrative and Technology Services |
| OMAP | Office of Medical Assistance Programs |
| OIG | Office of the Inspector General |
| ONC | Office of the National Coordinator for Health Information Technology |
| ORT | Operational Readiness Testing |
| OS | Operating System |
| OT | Occupational Therapist |
| PA | Prior Authorization |
| PACE | Program of All-Inclusive Care for the Elderly |
| PAPD | Planning Advance Planning Document |

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|---|---|
| PBM | Pharmacy Benefits Management |
| PC | Personal Computer |
| PCCM | Primary Care Case Management |
| PCP | Primary Care Provider |
| PDA | Personal Digital Assistant |
| PDL | Preferred Drug List |
| PET | Positron Emission Tomography |
| PET/CT | Positron Emission Tomography/Computed Tomography |
| PHER | Public Health Emergency Response |
| PHI | Protected Health Information |
| PHIN | Public Health Information Network |
| PHINMS | Public Health Information Network Messaging System |
| PHR | Personal Health Record |
| PI | Program Integrity Unit |
| POC | Point of Care |
| POS | Point of Sale |
| PPEC | Prescribed Pediatric Extended Care |
| Pro-DUR | Prospective Drug Utilization Review |
| PT | Physical Therapist |
| PTAN | Provider Transaction Access Number |
| PV | Patient Volume |
| QA | Quality Assurance |
| QI | Quality Improvement |
| QID | Quality Insights of Delaware |
| QIO | Quality Improvement Organization |
| QMS | Quality Management Strategy |
| R&A System | Medicare and Medicaid EHR Incentive Program Registration and Attestation System (previously known as National Level Repository or NLR) |
| RA | Remittance Advice |
| RDBMS | Relational Database Management System |
| REC | Regional Extension Center |
| REF | Research and Education Foundation |
| Retro-DUR | Retrospective Drug Utilization Review |
| RFP | Request for Proposal |
| RHC | Rural Health Clinic |
| RHIO | Regional Health Information Organization |
| RLS | Record Locator Service |
| SFTP | Secure File Transfer Protocol |

| | |
|---|---|
| SLRP | State Loan Repayment Program |
| SME | Subject Matter Expert |
| SMHP | State Medicaid HIT Plan |
| SOA | Service Oriented Architecture |
| SQL | Structured Query Language |
| SS-A | State Self-Assessment |
| SSL | Secure Socket Layer |
| SUR | Surveillance and Utilization Review |
| TAC | Technical Advisory Committee |
| TAP | Tracking Assessment and Planning |
| TEDS | Treatment Episode Data Set |
| TIN | Taxpayer Identification Number |
| TPL | Third-Party Liability |
| UAT | User Acceptance Test |
| URL | Uniform Resource Locator |
| URS | Uniform Reporting System |
| US | United States |
| VAN | Value Added Network |
| VB.NET | Visual Basic.NET |
| VFC | Vaccines for Children |
| VPN | Virtual Private Network |
| VRS | Voice Response System |
| WAN | Wide Area Network |
| XIX | Title 19 of the Social Security Act (Medicaid) |
| XXI | Title 21 of the Social Security Act (CHIP) |
| XML | Extensible Markup Language |

# 1 EXECUTIVE OVERVIEW

The State of Delaware through the Division of Medicaid and Medical Assistance (DMMA) or "the Division," is submitting this State Medicaid Health Information Technology (HIT) Plan (SMHP) as requested by the Centers for Medicare & Medicaid Services (CMS). This plan will describe the State's current and future HIT activities in support of the Medicaid Electronic Health Record (EHR) Incentive Program. In December 2012, the State submitted an update to this plan that was approved on March 13, 2013. The update included Stage 2 Final Rule changes (patient volume, hospital based exclusion of EPs, hospital changes, and Stage 1 MU measure changes). The original SMHP was approved through October 2013. The April 18, 2017 updated submission of the SMHP was reviewed and approved by CMS on June 28, 2017. We are updating that edition of the SMHP to reflect CMS' comments contained in Appendix A of the June 2017 approval letter. The State of Delaware is now submitting this State Medicaid Health Information Technology (HIT) Plan (SMHP) for approval. This plan describes the State's current and future HIT activities in support of the Medicaid Electronic Health Record (EHR) Incentive Program and describes the State's efforts to continue the HIT vision in Delaware. Delaware seeks CMS approval of this updated SMHP.

Delaware has worked collaboratively with the statewide HIE, Delaware Health Information Network (DHIN), the Regional Extension Center (REC) (when participating in Provider's attestations) and Hewlett Packard Enterprise Services (HPE), presently known as DXC Technology as of April 2017. DXC provides our Medical Assistance Provider Incentive Repository (MAPIR), which is Delaware's method for processing provider incentive applications and payments; provides technical assistance; and is contracted to form our Provider Incentive Payment Team (PIP). The PIP team works with providers to process their applications through the MAPIR system. Delaware collaborates with 14 other states that also use MAPIR to mitigate costs and share technology. Monthly HIT steering committee meetings are held in person, virtually or through email updates and includes the State HIT Coordinator, DMMA representatives from Managed Care, Program Integrity and Planning and Quality units as well as from the MAPIR PIP Team.

Since December 2011, the State of Delaware has provided incentive payments to over 700 unique providers including seven hospitals for adopting, implementing, or upgrading to certified EHR systems and for Meaningful Use of EHR technology. The Medicaid HIT program understands the necessity of having a successful DHIN in order to have a successful provider incentive program. A working relationship has been established between DMMA and the DHIN. This plan will show the current status of HIT in Delaware and explain the vision of HIT in the future and its impact on Medicaid.

## 1..1 Background

CMS implemented the EHR Incentive Program through the Health Information Technology for Economic and Clinical Health Act (HITECH) provisions of the American Recovery and Reinvestment Act of 2009 (ARRA). Section 4210 establishes an incentive payment program for Medicare and Medicaid providers to encourage the adoption and use of EHRs. The program provides incentive payments to Eligible Professionals (EPs) and Eligible Hospitals (EHs) as they adopt, implement, upgrade (A/I/U), or demonstrate MU of certified EHR technology. EPs can receive up to $63,750 over a maximum of 6 years of participation in the program. EH payments

are based on a number of factors and can be distributed over at least three years. The Medicaid EHR incentive program is voluntarily offered by individual states and territories and can begin in 2011. The program will continue until 2021. 2016 is the last year a Medicaid provider may begin participation in the program.

The SMHP focuses on Medicaid's role in the overall State strategic plan for HIE and will be reviewed by CMS and the Office of National Coordinator for Health Information Technology (ONC) to ensure a coordinated, integrated strategy for the Delaware EHR Incentive Program planning activities. Since implementation of the program, CMS and the ONC have worked together internally and with CMS Regional Offices to ensure a consistent and coordinated strategy for overall State HIT planning activities.

The EHR incentive program was established to address entry costs, as one of the main barriers to EHR adoption, by providing incentive payments to EPs and EHs participating in Medicare and Medicaid programs that are meaningful users of certified EHR technology. The payments are not a reimbursement; but, instead, an incentive made to EPs, EHs, and Critical Access Hospitals (CAHs) to A/I/U and appropriately use certified EHR technology. EPs, EHs, and CAHs participating in the Medicaid EHR Incentive Program may qualify in their first year of participation for an incentive payment by demonstrating the adoption (acquired and installed), implementation (trained staff, deployed tools, exchanged data), or upgrade (expanded functionality or interoperability) of a certified EHR. Incentive payments may also be disbursed to providers who demonstrate MU for an additional five years culminating in 2021.[1]

The ONC issued a closely related final rule that specified the Secretary's adoption of an initial set of standards, implementation specifications, and certification criteria for EHRs. Additionally, ONC issued a separate Rule related to the certification of HIT.

According to CMS, goals for the national program include:

1. Enhance care coordination and patient safety.
2. Reduce paperwork and improve efficiencies.
3. Facilitate electronic information sharing across providers, payers, and State lines.
4. Enable data sharing using State HIE and the Nationwide Health Information Network (NHIN).

Achieving these goals will improve health outcomes, facilitate access, simplify care, and reduce costs of health care nationwide.

The DMMA, since 2011, has worked closely with its federal and state partners to ensure that the Delaware EHR Incentive Program fits into the overall HIT strategic plan for the state, thereby advancing national goals for HIT and HIE.

### 1..1.1 Current Delaware Health Information Technology Landscape

[1] CMS Office of Public Affairs: 202-690-6145. CMS Proposes Requirements for the Electronic Health Records (EHR) Medicaid Incentive Payment Program. December 30, 2009.

Delaware is involved in a number of HIT activities that impact its Medicaid members, providers, other State agencies, and partners across the State. DMMA is fortunate to have an HIE (DHIN) in place and functioning. DMMA has collaborated with the DHIN activities to extend the HIT infrastructure to State Medicaid providers who attested A/I/U and MU to certified EHR technology. Further information describing the current HIT Landscape in Delaware is provided in Section 2.

#### 1..1.1.1 Use of Medicaid Information Technology Architecture (MITA) Principles and Methodology

DMMA completed its MITA State Self-Assessment (SS-A) in 2011 and on January 1, 2017 implemented the State's Delaware Medicaid Enterprise System (DMES), formerly the Medicaid Management Information System (MMIS). This assessment has provided the roadmap for activities that will help DMMA increase its MITA Maturity Levels (MMLs) for its inventory of MITA business processes. The current MMIS contract expired June 30, 2016, and was extended until December 31, 2016 and the DMES contract initiated at Go-Live on January 1, 2017.

This SMHP identifies those new or modified business processes necessary to operate the Medicaid EHR Incentive Program. An inventory of impacted business processes is found in Section 2.4.2, Table 4 of this document.

#### 1..1.1.2 As Is Environmental Scan

Delaware is seeing significant adoption of HIT in the provider community. The SMHP utilized a bi-yearly provider technology capacity study that indicated that electronic medical record (EMR) use has increased at a rate of 15 percent for primary care providers (PCPs) and eight percent for specialists between 2006 and 2008. In 2008, nearly 50 percent of Delaware physicians claimed to use some type of EMR technology. DHIN provider enrollment has grown significantly since its implementation in 2007. As of February 2016, DHIN participation statistics show the following:

- 100% of Delaware acute care hospitals (ACHs), including Nemours, Bayhealth Medical Center, Beebe Healthcare, Christiana Care Health System, Nanticoke Memorial Hospital and Saint Francis Healthcare, all major laboratories and radiology facilities, all skilled nursing facilities, and almost 100% of the State's medical providers who make orders (does not include Pathologists) participate in DHIN
- Two federally qualified health centers (FQHCs) are among the practices exclusively receiving results via DHIN
- More than 2.2 million unique patients are represented in the DHIN master patient/person index (MPI) including patients from all 50 states
- Almost 100% of providers currently practicing in Delaware are enrolled in DHIN
- Almost 100% of providers currently practicing in Delaware are enrolled in DHIN

- Approaching 100% of medical providers, who have enrolled and are participating in DHIN
- More than 14 million clinical results and reports are posted on DHIN each year

### 1..1.2 Vision of HIT Future

The State of Delaware has had a developing vision for the future of HIT since 1997 when legislation was enacted to establish the DHIN. In 2007, the DHIN became the first operational statewide HIE in the country. Over the years, the State has continued to augment and deploy DHIN across the state and continues to expand efforts for DHIN to support not only the state's providers but also other state agencies and programs in achieving automated exchange of health information to facilitate business operations. This plan shows the complementary vision between DMMA and other stakeholders such as the DHIN. The DMMA continues to align its vision with statewide efforts to realize a unified vision for DHIN.

Through the State Innovation Model (SIM) Test Grant and the Design Grant that preceded it, Delawareans have come together in an unprecedented collaborative effort to develop and implement a multi-stakeholder plan to improve health, health care quality and patient experience, and reduce the growth rate in health care costs. Delaware has developed a bold plan to improve on each dimension of the Triple Aim, plus one: to be one of the five healthiest states, to be among the top 10% of states in health care quality and patient experience, to bring the growth of health care costs in line with GDP growth, and to improve the provider experience.

The core elements of this plan include: 1) supporting local communities to work together to enable healthier living and better access to primary care; 2) transforming primary care so that every Delawarean has access to a primary care provider and to better coordinated care—between primary care and behavioral health, other specialists, and hospitals—for those patients with the greatest health needs; 3) across all payers, including Medicare, Medicaid, State Employees, and major commercial payers, shifting to payment models that reward high quality and better management of costs, with a common scorecard; 4) developing the technology needed for providers to access better information about their performance and for consumers to engage in their own health; and 5) providing the resources to the current health care workforce to transition to team-based care and employing strategies to develop the future workforce to meet the diverse needs of Delaware's population.

While Delaware's approach is consensus-based, the State will use its purchasing and regulatory authority to support these changes, including through its requirements for Medicaid Managed Care Organizations and Qualified Health Plans on the Health Insurance Marketplace. Public and private-sector leaders from across the state remain committed to the success of this initiative.

Through this plan Delaware aims for 90% of Delaware's 1,267 primary care physicians to participate, as well as advanced practice nurses practicing under the Collaborative Agreement, improving health and health care for nearly 800,000 beneficiaries across Medicare, Medicaid, State Employees, and major commercial payers.

### 1..1.3 Provider EHR Incentive Program Implementation

The backbone of the operational solution is the Medical Assistance Provider Incentive Repository (MAPIR), the DXC solution that was implemented collaboratively in 14 States. The Medicaid HIT Coordinator and staff participate in bi-weekly calls with the 14-State Collaborative to discuss MAPIR version changes. The Collaborative is led by Pennsylvania and their DXC MAPIR team. Medicaid Incentive Payments have been paid in Delaware to over 722 unique providers and total over $42 million. The DHIN, using funding from an ONC grant for Promoting HIT Adoption and Health Information Exchange Across the Continuum of Care, surveyed 100 of the 426 practices enrolled with the DHIN. This one-time survey was initiated on October 27, 2015 with aggregated results compiled on July 18, 2017. The survey asked two questions:

- Do you provide on-line access to patients through an Electronic Medical Records portal? 75% of the surveyed practices responded "yes."
- Which practices have met the benchmark of 5% of patients who have viewed, downloaded or transmitted their own data from the EMR? 55% of the practices, who met the MU measure of 5% patient engagement, have accessed the DHIN for medical data.

## Practices and Providers with EMRs which are DHIN-Certified*

| | Providers | Practices |
|---|---|---|
| **ADS** | 4 | 3 |
| **Advanced MD** | 15 | 7 |
| **AllMeds** | 9 | 1 |
| **AllScripts Pro** | 305 | 49 |
| **Amazing Charts** | 21 | 6 |
| **Aprima** | 7 | 3 |
| **Arete** | 41 | 15 |
| **Athena Health** | 51 | 18 |
| **Care 360** | 10 | 6 |
| **GE Healthcare (Centricity)** | 225 | 34 |
| **Cerner** | 161 | 53 |
| **Office Practicum Connexin** | 17 | 4 |
| **eCW** | 76 | 31 |
| **Epic** | 100 | 24 |
| **EyeMD** | 9 | 2 |
| **GEMMS** | 72 | 6 |
| **Glenwood Glace** | 3 | 1 |
| **Greenway** | 67 | 8 |
| **Health Fushion** | 9 | 3 |
| **Info Quest** | 2 | 1 |
| **McKesson** | 26 | 8 |
| **Henry Schein MicroMD** | 2 | 2 |
| **NextGen** | 47 | 3 |

| | | |
|---|---|---|
| **Bizmatics PrognoCis** | 2 | 2 |
| **Sequel Med** | 2 | 2 |
| **STI** | 107 | 44 |
| **Waiting Room Solutions** | 2 | 1 |
| **TOTALS** | **1392** | **337** |

**426 DHIN practices reporting that they use an EMR. 337 practices have an integration available to them (79%). 233 practices have a DHIN integration to their EMR (69%, 233/337)***

The integration and use of Certified Health Information Technology Systems (CEHRT) with the DHIN is the major end goal of provider participation in the EHR Incentive Payment Program in Delaware. The current HIT landscape and use of EHR is described below:

- Approximately 95% of DHIN participating practices currently use an EHR.
- 79% of practices with an EHR are using one of the 27 EHRs for which DHIN has a certified results delivery interface.
- The remaining 21% of practices use approximately 40 different EHRs, each with a very small footprint in the DE market, making it very difficult to engage these EHR vendors in the work to support the various types of exchange
- Almost all DE providers are receiving results and reports delivered through DHIN on behalf of the hospitals, labs, or imaging groups. These results are also archived in the DHIN Community Health Record to make them available for query by other health care providers. Currently, only about 13% of DE ambulatory providers are contributing data to the Community Health Record in the form of encounter-level CCDs. An unknown number of them may be engaging in point to point exchange with referral partners using secure messaging tools in their EHR.
- An unknown number of providers are accessing data through CommonWell Health Alliance (a Cerner health data exchange) or CareEquality (a national level, consensus-built, common interoperability framework to enable exchange between and among health data sharing networks).
- DHIN is currently in contract negotiations with a major provider of telehealth services (currently contracted to two of the three largest health systems in the state to provide telehealth services) to have them send summaries of telehealth encounters to the DHIN Community Health Record. This will provide a more complete longitudinal record of care, and will allow DHIN to leverage our notification services to inform the patient's PCP that a telehealth encounter has occurred. Initial implementation will be funded through DHIN's ONC grant (Advance Interoperable HIE), and ongoing costs will transition to private funding after the end of the grant.

### 1.1.4 Program Audit Strategy

The Program Integrity Unit (PI) of the DMMA is responsible for the detection and prevention of fraud, waste, and abuse. The following functions are performed by the PI:

- Creating audits and edits of the claims system so that claims with problems will not be paid
- Identifying clients who have other insurance so that Medicaid is the payer of last resort and recovering monies paid by Medicaid for clients that have other insurance
- Reviewing claims with possible problems and determining if payment should be made
- Identification, investigation, and referral of suspected provider and recipient fraud, waste, and abuse

The Surveillance and Utilization Review (SUR) Unit, of the PI monitors the utilization of Medicaid services to detect, investigate, and take action on findings of fraud, waste, and/or abuse. The SUR Unit fulfills section 42 Code of Federal Regulations (CFR) 455.1, which requires that states have a program in place for the identification, investigation, and referral of suspected provider and recipient fraud and abuse.

There are three components to the DMMA audit strategy related to the Delaware EHR Incentive Program:

- DMMA will avoid making improper payments by ensuring that payments only go to EPs and EHs who meet all incentive funding requirements.
- DMMA will ensure incentive payments are disbursed appropriately through a combination of monitoring and validation before payments are made.
- DMMA will identify suspected fraud and abuse through data analysis and provider audits. DMMA will perform targeted and random audits after payments are disbursed.

The DMMA HIT coordinator, with input from PI, developed a detailed audit protocol, designed to meet the specific objectives of the audit function described in Section 5. This protocol addresses the entire audit process, and includes:

- Steps to validate Medicaid and needy patient volume including claims data analysis and possible onsite verification of the provider's patient accounts
- Steps to verify adoption, implementation and upgrade, which will include a checklist and onsite review of the provider's use of EHR technology; obtaining documentation such as proof of purchase, vendor agreements; review of staff training; and determination that the EHR technology used is certified
- Steps to verify meaningful use for Stage 1, Stage 2 and Stage 3
- A detailed audit strategy has been designed and approved by CMS in January 2013 and updated and approved by CMS in December 2016 and again on June 19, 2017. DMMA has included, with this SMHP, an updated audit strategy to include audit procedures. The audit function is described in Section 5 and the audit strategy is found in Appendix C.

### 1..1.4 HIT Roadmap

The roadmap identifies the impact on MMLs (MITA Maturity Levels), benefits of future participation in the HIE, and uses of clinical and MU data.

# 2 CURRENT HIT LANDSCAPE ASSESSMENT – THE AS IS ENVIRONMENT.

The State of Delaware provides comprehensive medical assistance to approximately 245,670 eligible members under Title XIX of the Social Security Act through the Delaware Medical Assistance Program (DMAP) (as of September 2018). The DHSS is the single State agency mandated by the federal government and the State of Delaware to administer state and federally funded financial and medical assistance programs for Delaware's needy citizens. The DMMA manages most of the medical programs within DHSS and coordinates its efforts with other state agencies that provide medical services. DMMA has primary responsibility for administering Medicaid and the Children's Health Insurance Program (CHIP).

The mission of DMMA is to improve health outcomes by ensuring that the highest quality medical services are provided to the vulnerable populations of Delaware in the most cost effective manner. DMMA administers four major health care programs: Medicaid; CHIP; Delaware Prescription Assistance Program (DPAP); and Chronic Renal Disease Program (CRDP). In combination, these programs provide health coverage to approximately 245,670 individuals each month. Medicaid, alone, currently has over 234,952 enrollees. That is almost one out of every five Delawareans.

All traditional Delaware Medicaid benefits are included in the capitated benefit package with some notable exceptions. Dental, non-emergency transportation (NET), services offered through our PROMISE program that serves people with severe and persistent mental illness, and other services such as specialized services for children e.g., Prescribed Pediatric Extended Care (PPEC) are all excluded from the capitated benefit package. All non-capitated services, however, continue to be available to DSHP recipients and are covered by Medicaid and the State's DHCP program on a fee-for-service (FFS) basis or through other contractual capitated arrangements. Of the 245,670 Medicaid clients enrolled in the DSHP on September 2018, 208,924 are enrolled with one of two commercial managed care plans, Amerihealth Caritas and Health Options operated by High Mark Blue Cross Blue Shield.

DMMA is organized into the following areas of responsibility: Management Services which includes Accounting, Financial Management and Information Systems; Service Delivery which includes Managed Care Operations, and Training & LTC Eligibility Services; Program Integrity; Planning, Policy and Quality; Community Relations; Chief Medical Officer.

DHSS contracts with a FA, DXC, to support Medicaid operations. The FA operates and maintains the DMES in addition, DHSS contracts with the FA for claims processing, pharmacy consultant services, a client pharmacy call center, provider relations, and drug rebates, invoicing and collection, DPAP processing, third-party liability (TPL) verification and lead processing, Drug Utilization Review (DUR), Health Benefit Management services, Health Care Program Premium processing, some auditing functions and ad-hoc query environment management.

Medicaid modernization remains a high priority today for DMMA. Advances in HIT, including the deployment of EHRs, HIE, and the need for interoperability across systems to support patient safety and quality of care, are driving forces in health reform and other efforts to improve care and reduce unnecessary costs. Alignment with national health initiatives, such as the NHIN, makes the potential for using business data to develop performance metrics for evaluating health outcomes at all levels of health care delivery systems extremely viable.

The Division developed the original SMHP in the context of the coordinated efforts with other recipients of ARRA HITECH funds such as DHIN and QID. This ensured that EHR systems and the HIE could be leveraged to their full capacity in supporting Medicaid's HIT plans. This collaboration ensured that HIT investments by the State and the federal government are maximized and economies of scale are realized throughout implementation of this SMHP. The Division continues to collaborate on approaches to promote EHR use and connectivity which support improved care management, improved communication with Medicaid providers, and efficiencies in medical management for Delawareans.

## 2..1 Current HIT Activities and Impact on Medicaid Beneficiaries

Appropriate utilization of HIT will help improve the quality and efficiency of health care while reducing costs. The foundation has been laid over the past several years to move Delaware in a direction that provides a positive impact to both healthcare providers and recipients. The DMMA has taken an active role in the HIT endeavors as described below.

**E-Prescribing**

The DMMA implemented an e-Prescribing Program funded through a CMS Medicaid Transformation Grant (MTG) in November 2008. DMMA implemented a full e-Prescribing solution that provided real-time MMIS information to a hub that allowed access to the data regardless of the technology used. Additionally, a pilot program provided software and personal digital assistants (PDAs) to select physicians that did not currently have e-Prescribing capabilities. The system provides physicians the following features:

- Real-time Medication History
- Benefit Plan
- PDL
- Prior Authorization (PA) Requirements (with Uniform Resource Locator (URL) to PA form)
- Clinical Decision Support
- Warnings and Alerts
    - Drug/Drug Interactions
    - Duplicate Therapy
    - Dosage Limits
    - Early/Late Refill

- Quantity Limits
- Allergy Alerts

The Delaware approach uses Surescripts, which is a leader in transaction processing between payers, pharmacy benefits management (PBM) firms, and point of care (POC) technology vendors on behalf of physicians and pharmacies. With universal payer enablement of the Delaware Medicaid data, practitioners are free to use any POC technology vendor to deliver in-office stand-alone or EMR technology This allows practitioners to choose POC technology vendors for e-Prescribing and/or EHRs that best meet the needs of their practices, yet still have all of the functionality available with the National Council for Prescription Drug Programs (NCPDP) script standard transactions. Interfaces with Surescripts are kept current and up to date with industry standards. Surescripts also tracks adoption and usage of e-Prescribing for Delaware on its web site at http://www.surescripts.com/about-e-prescribing/progress-reports/state.aspx?state=de&x=40&y=16.

Delaware FFS discontinued the E-Prescribing capability on July 1, 2015. Managed Care plans are actively E-Prescribing. We worked with the DMMA Managed Care Operations Unit to establish reporting on e-Prescribing for the future. We will have an updated report in the next SMHP update in 2019.

**Medicaid Electronic Verification System (EVS)**

The EVS provides fast, efficient and accurate verification services to all DMAP providers. The EVS system furnishes providers with accurate and timely information, communicated in an easy-to-understand format. These services improve provider efficiency and accuracy when assisting Medicaid clients. The EVS “umbrella” supports many access methods as described below:

- Internet-Based EVS - An interface to the DMES utilizing Internet-based technology that allows for verification of client coverage and other services through a secured Internet web site. EVS allows access to the following:
  - Eligibility program information, including TPL, such as managed care enrollment, lock-in status, and program limitations
  - Claim status
  - Check-write
  - Client service limits
  - PA inquiry
- Telephone/Voice-Based EVS - An interface to the DMES using voice response hardware and software. The Voice Response System (VRS) is an automated system accessed by touch-tone telephone to provide information regarding client eligibility and other coverage in addition to other verification services.
- Electronic Commerce Management Service (ECMS) - An interface to the DMES using the ECMS allows for the drop-off and pick-up of the following data in Health Insurance Portability and Accountability Act (HIPAA) standard formats:

  - Interactive eligibility program information, including TPL, such as managed care enrollment, lock-in status, and program limitations
  - Batch eligibility program information, including TPL, such as managed care enrollment, lock-in status, and program limitations
  - Batch claim status
- Point of Sale (POS) systems - Electronic messages submitted interactively, as opposed to batch, through a POS device or through personal computer (PC)-running, POS emulation software, allow providers to interface with the DMES through ECMS and obtain current eligibility and other coverage. Providers may also use magnetic swipe eligibility cards in conjunction with their POS systems to obtain current eligibility, TPL, managed care enrollment, lock-in status, and program limitations.
- Provider Electronic Solutions software/approved third-party vendor software - A software package that allows providers to access verification services and claims submittal using a computer. These transactions interface with the MMIS through ECMS.

**Master Client Index (MCI)**

DHSS maintains an MCI system which assigns a unique identifier to each client in the department's programs and services including Medicaid recipients. This identifier is created during the process of applying for benefits from multiple state agencies and is assigned to the recipient for life. Once the MCI is created, it is shared with other program systems within and outside of DHSS. Among the agencies sharing MCI data are: DMMA, Division of Social Services (DSS), Division of Public Health (DPH) (clinics, immunizations, and lab services), Division of Child Support Enforcement (DCSE), and the Division of Substance Abuse and Mental Health (DSAMH). The use of an MCI improves coordination of various programs and services offered by DHSS.

**DHIN**

The Delaware Health Information Network (DHIN) is a not-for-profit instrumentality of the State of Delaware with the statutory purpose to develop and operate a state-wide health information network integrating clinical, financial, and patient satisfaction data sources to inform decisions (16 Del Code § 10303). Expected benefits are improved communication within the healthcare community, improved efficiency and elimination of redundant testing, monitoring of population health and community health status, reduction in healthcare costs, and serving as the trusted source of information for consumers and purchasers as well as providers of care. DHIN is governed by a public-private board which includes individuals with various business, technology and healthcare industry skills committed to managing the Corporation in an efficient, effective and competitive manner. 16 Del. C. § 10302. DHIN is the state sanctioned provider of HIE services, and is the only public HIE in the state of Delaware.

Current participation rates are:

- 100% of Hospitals in Delaware
- 100% of Delaware's long term care and skilled nursing facilities
- 98% of Health Care Providers in Delaware

More than 14,000,000 clinical results and reports are posted on DHIN each year. DHIN processes 40 million transactions per year. The total patient records in the system now exceed 2.2 million with patient records from all 50 states. The majority of Medicaid patient clinical data already exists in the DHIN clinical repository, and assists hospitals and physicians in treating Medicaid clients each day.

**Current DHIN Services and Capabilities:**

DHIN-to-EHR Integrations - As a special instance of Electronic Clinical Results Delivery, DHIN can interface to any electronic health record (EHR) capable of connecting via a web-service interface using Health Level Seven (HL7) standard language. The advantage of such an integration over other forms of results delivery is that the end user requires no special effort or actions to receive their results – they are delivered automatically into the EHR and accessible in the normal workflow of the user. Once DHIN certifies that a single interface to DHIN pulls all data types from all data senders and these results are stored and displayed correctly in that EHR, the vendor is free to market it as a DHIN-certified results delivery interface and sell it to all their clients who are DHIN members. There are currently certified results delivery interfaces from DHIN to 26 EHRs, representing 76% of EHR users in the state.

Single Sign-On (SSO) - A user experience pain point for providers has been the necessity to authenticate into multiple systems while in the same user interface. DHIN partners with EHR vendors to solve this problem by allowing seamless access into the DHIN Community Health Record, using the authentication credentials of the EHR system.

Care Summary Exchange - Providers and practices using certified EHR technology (CEHRT) are able to send to DHIN a summary of care using the C-CDA standard following each ambulatory visit. DHIN makes these available for viewing within the CHR as an additional data type, and provides reports to the sending practices on the number of views of this data for purposes of Meaningful Use reporting. DHIN will also shortly be making these summaries available to patients who enroll in the state-wide PHR/patient portal and provide Meaningful Use reporting to the sending practices on a range of consumer engagement objectives. DHIN is currently exploring the feasibility of using these care summaries as the source for clinical quality reporting on behalf of the sending organizations. At this time, approximately 13% of Delaware ambulatory providers have subscribed to this service.

Clinical Gateway - For organizations which already have analytics tools and just need the data, DHIN is able to match incoming data from all sources against a watch list of patients provided by a subscribing organization and route a copy of the data to that organization, thus permitting them to apply their own tools for analysis. Large health systems can utilize this valuable data in support of their population health initiatives.

Community Health Record - All clinical data from all data sending organizations is aggregated into a composite longitudinal record for each patient. This record can be queried by properly privileged users for both previously unknown patients and unknown data about a known patient. This aggregated view of the patient across geography, time and care settings is core to DHIN's value proposition. The Community Health Record contains health data on nearly all Delawareans, as well as patients from all 50 states. In addition to information from Delaware facilities on Delaware patients, DHIN also receives information on Delaware patients from providers/facilities in other states.

Out-of-State Connections: - DHIN and the Maryland state HIE, Chesapeake Regional Information System for Our Patients (CRISP) exchange ADTs based on the state of residence of the patient. CRISP also provides the infrastructure for HIEs for Washington, DC and West Virginia, which enables DHIN to receive ADT data on Delawareans who receive care in any of these markets. DHIN also exchanges information with NJSHINE, the HIE covering the southern counties of New Jersey, for similar exchange of ADTs based on state of residence of the patient.

Event Notification System - DHIN uses the ADT data coming from Delaware, Southeastern Pennsylvania, New Jersey, Maryland, West Virginia, District of Columbia, and Ohio hospitals, emergency departments, and participating walk-in clinics to match against a watch list of patients for whom a subscriber wishes to receive notifications. Notifications can be delivered real time or batched for delivery at intervals of the user's choice. Forty nine percent of Delaware residents are covered by a health plan using this service for purposes of outreach and care coordination. Approximately 17% of Delaware's ambulatory health care providers have also subscribed to this service for purposes of care coordination and transitional care management.

API to DHIN clinical data for use by their PHR - Many hospital systems and other data providers offer a Personal Health Record (PHR) for use by their patients to view information generated by the given health system. Typically though, the patient is only able to see information created by that health system. As a result, the patient is only able to see a limited amount of information, and if the patient wants to see more of their information, they would need create credentials and log in to another PHR system, creating frustration and dissatisfaction for the patient. DHIN offers the ability for the hospital to create an Application Program Interface (API) which links the hospital's system to DHIN's data repository and provides the ability to send patient information from all of DHIN's 26 primary data providers and out of state ADT providers to the hospital's PHR system so that the patient can view all of his/her information within the hospital's PHR setting, thereby creating hospital loyalty by the patient as they can view all of their information in that hospital's PHR system. In addition, patient satisfaction increases as he/she no longer needs to go to multiple PHR systems to obtain their information.

Care Summary Creation and Download - As part of the Community Health Record, DHIN provides the ability to create a Continuity of Care document (CCD) from within the DHIN Community Health Record which includes all data from all data senders. The user may apply filters to limit the date range or specific data types to be included in the composite CCD. The resulting document may then be downloaded to the user's local environment, either in a pdf format, or as structured data if their EHR has the ability to consume it as such. Thus, even without an integration between DHIN and the user's EHR, the capability exists to incorporate data from the Community Health Record into the user's EHR and make it a part of their local record of care.

Statewide Patient Portal/Personal Health Record (PHR) - Because DHIN receives data from many sources, it is uniquely positioned to provide patients/consumers with access to their personal health data with minimum effort. For practices that have already implemented a patient portal, an API connection to the DHIN data repository allows data from all sources to be retrieved and presented upon patient login to the hospital or practice portal. For those who have not yet implemented a portal, DHIN offers a co-branded implementation of the tool we are calling "Health Check Connect." This not only provides access to the data in the DHIN data repository, but offers additional features and functions, to include secure messaging between providers and patients, patient education resources, and interfaces to various medical devices, such as digital scales, glucometers, blood pressure measuring devices, exercise/activity trackers, and others. The patient will have the option to select

their language preference when they set up their account. At launch, supported languages will be English, Spanish and Romanian, with plans to add others as fast as translators can be found to assist with the mapping.

Medication History - This is a value-added subscription service which allows a user of the CHR to retrieve 12 months of prescription fill history (provided by a number of national sources, to include SureScripts, health plan pharmacy benefits managers, and others) upon demand. For those who do not choose to subscribe to the full service, there is a URL link embedded in the DHIN web portal that takes the user to the Delaware Prescription Monitoring database, where they can at minimum (and for no charge) view the controlled substance fill history for the patient.

PACS Image Sharing - St Francis Hospital, Mid-Del Imaging, and Nanticoke Hospital have implemented an image sharing service through DHIN. URL links are added to the radiology reports sent into the DHIN Community Health Record. These links interface with the source imaging system or an offline cache of recent images, giving providers the capability to view images from the DHIN CHR portal, and even compare with previous studies. The three currently participating data senders account for 11% of all imaging results sent into the Community Health Record, and span the three counties of the state.

DHIN Electronic Public Health Reporting - DHIN connects to the state's public health electronic lab reporting system for real-time delivery of reportable diseases. Through the emergency department (ED) admission transactions, DHIN receives the relevant lab report for the patient's visit and routes it to the patient's provider, as well as to the Delaware Electronic Reporting and Surveillance System (DERSS) in real-time standardized format. By state regulation, all Delaware hospitals must send this data through DHIN to Public Health, using the most current technology standards.

DHIN Electronic Syndromic Surveillance Reporting - DHIN connects to the state's public health bio-surveillance system for real-time delivery of emergency chief complaint data. Through the emergency department (ED) admission transactions, DHIN receives the relevant chief complaint for the patient's visit and routes it to the patient's provider, as well as to the Delaware Electronic Reporting and Surveillance System (DERSS) in real-time standardized format. By state regulation, all Delaware hospitals must send this data through DHIN to Public Health, using the most current technology standards.

DHIN Immunization Registry and Query - DHIN provides a web-service that enables both electronic reporting to and query of the state immunization registry, DelVax. Automating the submission of this data electronically through a web service interface improves reporting timeliness and accuracy and results in a more up-to-date record of each patient's immunization status. Currently, this service is used by 100% of Delaware hospitals, 77% of Delaware pharmacies, and 32% of ambulatory practices, with many more in various stages of testing or onboarding.

DHIN Newborn Screen Electronic Reporting - Newborn screening consists of early hearing detection and a set of lab tests for early detection of harmful metabolic and congenital conditions. DHIN has worked with Public Health and the state's hospitals and birthing centers to enable the electronic reporting of early hearing detection testing through DHIN to Public Health. DHIN is currently working

with Public Health to automate combining the results of the hearing detection and metabolic screening into a composite newborn screening report that can be delivered by DHIN to the birth hospital and the provider who will be caring for the baby.

Consulting Services - DHIN has provided consulting services to the state of Hawaii in standing up their HIE, and has provided varying levels of consulting support to other states on specific topics.

Direct Secure Messaging – This service enables secure, encrypted point-to-point exchange of information between individual entities or organizations which have established a trust relationship, using the ONC-adopted standard for such communication. Many but not all providers receive this service directly from their EHR vendor, but DHIN offers the option for users to subscribe to this service through us if they do not already have access to it from other sources. We have a few subscribers among organizations not yet using an EHR, to include paper-based practices and provider types not eligible for the CMS EHR Incentive Program (primarily behavioral health and long term and post-acute care organizations. Adoption of this service is low.

Specimen Location for Research – This service enables DHIN to connect researchers looking for biological specimens (blood, serum, tissue, etc.) meeting specified parameters with laboratories holding specimens meeting those parameters. With patient consent, once biologic specimens have been used for the intended clinical purpose, the residuals which remain and would otherwise be discarded can be made available to researchers under IRB-approved research protocols.

Analytics/Reporting Service

DHIN has recently launched an analytics and reporting service, used primarily by ACOs who seek to understand the activity of their patients outside their own network. Because DHIN receives data from all hospitals, labs, and nearly all imaging centers as well as a small but growing number of ambulatory practices and urgent call centers/walk-in clinics, DHIN is uniquely positioned to provide this service.

Fraud Detection

DHIN's "Health Check Alert" service allows subscribing patients receive a text message alert whenever new data is received by DHIN about them, or whenever a user accesses their information in the Community Health Record. Similar to the processes used by credit card companies for fraud alerts, the patient then sends a simple reply indicating whether they do or do not recognize the activity as legitimate. Additional benefits to the patient include the knowledge of who is accessing their health data, and awareness of when test results are available, both to the ordering provider and to the patient directly through a patient portal/PHR. Health plans are also target customers as receiving notifications from their patients about an incorrect transaction allows them to pursue any potential fraudulent activity before the claim is paid.

## DHIN Services Currently Under Development:

Health Care Claims Database (HCCD) - The Delaware General Assembly passed legislation in 2016 authorizing DHIN to stand up a Health Claims Database. Reporting to this database will be required for Medicaid and state employee health plans, qualified health plans on the Marketplace, and federal sources such as Medicare. Other health plans may report data on a voluntary basis. Broad use cases contemplated include support for population health initiatives, provider risk sharing, and consumer shopping. DHIN has recently completed a successful proof of concept and began receiving data in May of 2018.

Medical Orders for End-of-Life Care - The Delaware General Assembly has enacted legislation to establish a common form and accompanying policies and procedures to incorporate patient end-of-life care preferences into a concise set of medical orders (DMOST) which must be honored across the state in all care settings. DHIN is authorized to establish a registry for these orders. We are currently working with the DMOST working group to develop and implement this registry.

## DHIN Functionality – Future Plans

Mental Health/Behavioral Health Data Exchange - Exchange of mental health data requires more than the usual privacy and security tools. DHIN currently is able to support the granular patient consent that is necessary to restrict viewing of behavioral health data to specific individuals the patient has consented to have such access. Few behavioral health organizations in Delaware currently use electronic health records, but as this number grows, there will be value in including such data in the Community Health Record.

New data types and data sources - The social value of the Community Health Record as well as the value of the DHIN data repository is greatest if all the data are "in" and all the healthcare community is using it. The value can be augmented with the addition of:

- Ambulatory data – DHIN expects to continue a focus on the goal of widespread CCD contributions from the ambulatory setting. Currently, approximately 13% of DE providers contribute such data.
- Claims data – many elements of a claim are useful proxies for clinical information, such as procedure and diagnosis codes, as well as a complete listing of providers seen and medications filled. DHIN has a data use agreement with the dominant carrier in our market, but we have not yet implemented the data feeds for the use of incorporating this data for clinical use.
- Medical device data – EKGs and other devices with output which is graphic or pictorial rather than primarily text or number based, as well as home glucometers and scales would provide very valuable additions to the Community Health Record and enhance care across the care continuum.
- Data from the long term and post-acute care (LTPAC) organizations – These data sources are very important to support the analytics needs of ACOs and providers considering entering into risk-bearing contracts. A small but growing number of LTPAC organizations use electronic health records, but a solid business case to entice them to participate in the information exchange ecosystem has been elusive. DHIN will continue efforts to engage this important group.

Care Gaps - Based on accepted clinical guidelines and using all data from all sources contained in the DHIN repository, DHIN would provide notification of possible gaps in care to enable proactive case management and care coordination.

Risk Stratification - Identify high risk patients for special care coordination. This is a necessary activity under some of the newer delivery and payment models, such as Patient Centered Medical Home. The cost of providing this service could be reduced if a single tool and set of risk stratification algorithms is used across the state.

Clinical Quality Measure Reporting - Practices may be reporting under multiple programs, such as Meaningful Use, MIPS, and to one or more health plans. DHIN could be the clearing house such that the practice submits all measures once to DHIN, and DHIN reports out to the various end points. DHIN aspires to become a Qualified Clinical Data Registry for this purpose.

## Discontinued Services

Common Provider Scorecard - Under one of the initiatives of the State Innovation Model (SIM) grant received by Delaware, the major carriers and health plans have agreed on a common set of clinical quality measures, utilization metrics and cost metrics and they report this data to DHIN quarterly. DHIN then publishes a Common Provider Scorecard which enables subscribing providers to see their performance on these measures across their entire practice and also stratified by payer and health plan.

**Vendors with a Certified DHIN EMR:**

DHIN currently has certified results delivery interfaces through 27 different EMR vendors. DHIN can interface to any Electronic Medical Record (EMR) product that is capable of connecting via a web-service interface using HL7 (health level 7) standard language.

**Vendors with a Certified DHIN Interface:**

- ADS (Advanced Data Systems)
- AdvancedMD
- AllMeds
- Allscripts (Including Eclipsys)
- Amazing Charts
- Aprima
- Arete
- Athena
- Bizmatics/PrognoCis
- Cerner
- eCW (e-Clinical Works)
- Epic
- EyeMD EMR Healthcare Systems
- GE Healthcare (Centricity)
- GEMMS
- Glenwood/Glace
- Greenway
- Healthfusion
- InfoQuest
- McKesson (Practice Partners & Horizon)
- MedPlus – Care360
- MicroMD
- NextGen
- Office Practicum (Connexin Software)
- SequelMed
- STI Computer Services

- Waiting Room Solutions

## 2..2 Current HIT Activities and Impact on EHR Incentive Program

All of the activities described above provide infrastructure and foundations to support a variety of State stakeholders and initiatives under the larger umbrella of the State's HIT efforts. Delaware Medicaid and key DMMA personnel are involved in many of these efforts, either independently or as a part of the State's governing bodies. These activities will also impact Delaware's EHR Incentive Program by providing the infrastructure for using EHRs, not only within a single organization, but also to facilitate sharing and usage across organizational and geographical boundaries. The state is engaged in statewide HIT activities and has built awareness among stakeholders across the State. This has facilitated the promotion of the Delaware EHR Incentive Program. Several activities, such as the State HIE Cooperative Agreement and the REC programs, are specifically designed to work with and support the Delaware EHR Incentive Program, and provided additional motivation and business reasons for providers to participate.

DHIN is the State-designated entity for HIE. DHSS under the direction of DHIN is working toward the goals set in the HIE Cooperative Agreement. The following organizations are collaborating with DHIN to develop the tasks outlined in the HIE Cooperative Agreement:

- DHSS divisions collaborating with DHIN include:
    - Division of Developmental Disabilities Services (DDDS)
    - DMS
    - DMMA
    - Department of Services for Children, Youth, and Families (DSCYF)
    - DPH
    - DSAMH
    - Delaware Health Care Commission (DHCC)
- The Department of Technology and Information (DTI)

## 2..3 SMHP Development

In 2010, Delaware submitted a HIT Planning Advance Planning Document (PAPD) to CMS for approval. The PAPD was approved on 10/22/2010 by CMS. DMMA then awarded a contract for consultant services to assist the state with the planning process and development of the SMHP and Implementation Advance Planning Document (IAPD). The IAPD and the SMHP were both submitted to CMS for review. Approval date of the original IAPD was May 11, 2011 and the SMHP was first approved on December 22, 2011. An updated IAPD was approved on February 21, 2013 and a revised updated IAPD was approved April 30, 2013. The SMHP update for Stage I and Stage II amendments was submitted in December 2012 and approved March 18, 2013. A revised, updated SMHP was submitted November 1, 2013 and approved November 25, 2013. An addendum to the SMHP was approved December 4, 2014 for the Flexibility Rule changes. An

additional addendum to the SMHP was approved January 28, 2016 for the EHR Incentive Program in 2015 through 2017 (Modified Final Rule) as well as Stage 3 in 2018 and beyond. Recently, an addendum for Program Year 2017 was developed and submitted to CMS for approval in February 2017 and was approved on March 20, 2017.

**Delaware State Medicaid HIT Plan Addendum for Program Year 2017 EHR Incentive Payment Program Requirements**

The Delaware Department of Health and Social Services, Division of Medicaid & Medical Assistance complies with federal regulations and guidance from the Centers for Medicare & Medicaid Services (CMS) to administer and oversee Delaware's Medicaid's Electronic Health Record Incentive Program. This State Medicaid Health Information Technology Plan (SMHP) Addendum provides CMS with an overview of the Division's changes for Program Year 2017 to accommodate the requirements in the Modified Meaningful Use for 2017; the OPPS Rule and the Medicare Quality Payment Program (QPP) also referred to as MACRA/MIPS.

Delaware is a member of the Medical Assistance Provider Incentive Repository (MAPIR) Collaborative. The impacts summarized in the table below, as well as the plan to address the impacts for Program Year 2017, are in alignment with the Core MAPIR specifications that have been designed and implemented in MAPIR version 6.0. PY2017 screen changes and system updates were submitted and a MAPIR Collaborative walkthrough of MAPIR 6.0 was conducted with CMS on 1/18/2017. Approval for Core MAPIR system and screen changes was received on **March 20, 2017.**
MAPIR 6.0 is scheduled to be released to MAPIR Collaborative states in mid-May 2017. Delaware customization and deployment of MAPIR 6.0 will allow providers to proceed with attestations under the newest rules, and is estimated to be accomplished for availability to Delaware Medicaid EHR Incentive Payment Program participants by October 15, 2017. The Delaware Medicaid EHR Incentive Payment Program will not request a tail extension period after March 31, 2018 for Program Year 2017 applications.

| | Regulation and EHR Program Requirements | Brief Explanation of Requirement and SMHP Addendum Impact | Rule Reference Link | SMHP Addendum Updates (Can use checkmark or enter date when requirement has been addressed) | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | Program | System | Policy | Audit | Notes |
| A | **2015-2017 Modifications Rule** | | | | | | | |
| 1 | **Option to attest to Stage 3 in 2017** | Providers have the option to attest to Stage 3 in 2017. States should describe changes (program, system, policy, audit) being made to be prepared to address the option in 2017. | https://www.federalregister.gov/d/2015-25595/p-2152 | ✓ | Available Est. 10/15/17 | ✓ | ✓ | Modified MU Stage 2 and MU Stage 3 pre-payment application review spreadsheets and administrative tools were submitted and approved as part of the Audit Protocol on December 6, 2016. Provider Education and Outreach activities will be ongoing through regular email notifications, blast FAX, website updates, and webinars. Any further Audit Protocol revisions for PY2017 to be submitted around December 2017. |
| 2 | **Program Year 2017 MU Requirements** | 2017 includes updates to the MU objectives and states need to discuss how they will administer attestations that include EHR period that are within 2017. | https://www.federalregister.gov/d/2015-25595/p-2843 | ✓ | Available Est. 10/15/17 | ✓ | ✓ | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| B | **OPPS Rule** | | | | | | | |
| 1 | **90-day EHR reporting period** | All providers will attest to a 90-day EHR reporting for 2017. Define, design and submit any updates to SLR screens and preliminary audit strategy changes, along with policy updates pertaining to the 2017 "EHR reporting period" parameters. | https://www.federalregister.gov/d/2016-26515/p-3657 | ✓ | Available Est. 10/15/17 | ✓ | ✓ | MAPIR has configurable settings for EHR Reporting Periods per Program Year, but no separate system inputs for CQM reporting periods. Therefore, MAPIR 6.0 contains an enhancement that will prevent providers subject to the Full Year CQM reporting period requirement from submitting a PY2017 application before 1/1/18. A possible complication is that providers may switch practices, and therefore not have a full year of CQM data with the second practice with whom they are attesting. The practice that the provider left may not be willing to share CQM data, especially since they are not receiving an incentive payment. Delaware will allow providers who were not at their attesting practice for a full year to use abbreviated CQM data solely from the attesting practice. This will be reviewed and documented pre-payment when the date ranges on the CQM and MU reports are compared to the attested date ranges. This will also be reviewed post-payment on attestations selected for audit. |
| 2 | **Modification to measure calculation timeframe** | Measure calculations were modified to require that actions included in the numerator must occur within the EHR reporting period. States should outline the changes (program, system, policy, audit) they are making to address this requirement. | https://www.federalregister.gov/d/2016-26515/p-3723 | ✓ | Available Est. 10/15/17 | ✓ | ✓ | |
| C | **Medicare Quality Payment Program (QPP)** | | | | | | | |
| 1 | **Updates to definition of Meaningful EHR User** | Definition now includes demonstration of supporting information exchange and prevention of information blocking. States should identify what changes (program, system, policy, audit) they will make to address updated definition within SMHP addendum. | https://www.federalregister.gov/d/2016-25240/p-6988 | ✓ | Available Est. 10/15/17 | ✓ | ✓ | MAPIR 6.0 screen changes will accommodate these additional requirements by asking providers yes/no questions about their compliance. Providers' responses to these questions will be captured and recorded as part of their attestation. The question responses will be reviewed manually as part of pre-payment verification procedures. When responses indicate compliance, no additional steps will be taken. Provider outreach will occur as necessary when required responses indicate non-compliance. Payment will not be made unless it is deemed that the requirements have been reasonably satisfied and there is sufficient explanation and/or documentation. |
| 2 | **Demonstration, via attestation, of updated Meaningful EHR user definition.** | The Final Rule lists specific statements that providers participating in the Medicaid EHR Incentive programs must attest to for EHR reporting periods beginning in 2017. States must address changes (program, system, policy, audit) within SMHP addendum. | https://www.federalregister.gov/d/2016-25240/p-7001 - for EPs<br>https://www.federalregister.gov/d/2016-25240/p-7019 - For EH/CAHs | ✓ | Available Est. 10/15/17 | ✓ | ✓ | |

## 2..4 HIT Landscape Environment

Delaware has invested in statewide HIT efforts through the DHIN since 1997, and has engaged in a number of activities that further the development of infrastructure, stakeholder awareness and involvement, and other foundations that support and enhance the progress of these efforts. The Division is an active participant since the beginning, and has played key roles in furthering the larger goal of achieving broad automation, interoperability, and exchange in the state.

The Division participates in and interoperates with the projects, systems, and networks that are established to support the state's HIT goals. The current HIT landscape for DMMA is described in this section.

### 2..4.1 Existing HIT and Data Resources

There are a number of existing HIT efforts and systems that support the Medicaid Enterprise, as well as, the general population in Delaware. As described in section 2.1, there are several existing HIT initiatives that impact the citizens of Delaware and specifically provide a foundation for successful adoption of EHRs/EMRs that are capable of MU. However, in addition to these

previously discussed HIT initiatives there are several other programs that could contribute to the continued deployment of HIT in Delaware.

## DPH Activities:

### Electronic Medical Record (EMR) Systems for Public Health Clinics

DPH implemented a clinical EMR and a dental EMR in 2012. Since the initial implementation, several components have been added to the initial platform. Both EMRs have incorporated access to the state master client identifier process that is used to determine Medicaid eligibility.

A connection to a clearing house was established which allows for electronic billing for appropriate services. Work is underway to expand the electronic billing module to include electronic processing of third party billing vendors.

The EMR was merged with other Department of Health and Social Services EMR projects to allow future integration, interoperability and data sharing between agencies across the Department. Electronic lab orders and results were implemented between the Delaware Public Health Laboratory and the clinic EMR. Electronic updates and queries to the State Immunization Registry were built for the EMR. A case management process flow was implemented for the TB clinics and increased reporting capability for Smart Start was added to meet federal reporting requirements.

The current EMR core functions and will be expanded as funding becomes available to support other case management activities such as HIV/AIDS case management, possible School-based wellness activities, data capture for increased analytics, expanded data sharing with the State Health Information Exchange and additional electronic billing opportunities to improve revenue collection.

### Cancer Registry

The Cancer registry is now being updated electronically by a few external labs. Several providers are working with the State and their EMR vendors to also update the registry directly from their EMR systems.

### Vital Statistics Systems:

The current Delaware vital statistics system includes six types of vital events: births, deaths, marriages, divorces, fetal deaths, and induced terminations of pregnancy. Records are entered by both agency and provider staff. Data elements are used to produce numerous public health reports. This allows for the reporting of information such as date of death across other systems in DHSS to appropriately close out case records. The Delaware Health Statistics Center implemented the Electronic Vital Records System (EVRS) for births in 2006 and deaths in 2007. This EVRS creates a state of the art database for collecting and compiling birth and death data from vital records, and enhances reporting ability for Delaware vital record data. Implementation of the EVRS

Web interface enables birth and death certificates to be prepared and submitted electronically through a secure web site. The system was updated in 2012 to allow processing of civil unions. In 2013, the system was updated to allow same-gender marriages. Information from the Vital statistics application are critical for all applications within DPH being the source of record for birth and death and providing initial identifying information for immunizations and newborn screening.

**DHIN/Newborn Hearing and Metabolic Screening partnership**

DPH and the DHIN are finalizing a process to electronically send a combined metabolic message to the State Health Information Exchange, the DHIN, to be delivered to the birth provider. The message will contain the hearing results which are sent to DPH directly from the Newborn Hearing Screening equipment and combines the hearing results with the electronic laboratory results from the metabolic testing.

**Division of Public Health Laboratory (DPHL)**

The Public Health Laboratory Information System (LIMS) sends non-restrictive lab results to the DHIN. In addition to the electronic ordering of lab test from the DPH EMR, DPHL completed a project with Planned Parenthood of Delaware (PPDE) for electronic ordering of test to the DPHL and electronic receipt of test results to the PPDE EMR. Conversations have commenced to provide the same service to the Delaware Department of Corrections.

**Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE)**

DPH implemented ESSENCE, a web-based data acquisition, analysis, visualization, modeling, and simulation tool used to monitor disease trends and more rapidly identify disease outbreaks. The system captures chief complaint data from hospital emergency departments, commonly referred to as syndromic surveillance data, and runs spatial and temporal algorithms on this data in addition to public health case data (i.e., reportable diseases) across the state.

**Zika Pregnancy Registry**

DPH was awarded a grant to improve the reporting and surveillance of Zika virus disease. Creation of the Zika Pregnancy Registry will improve the reporting process and result in a more reliable and accurate data transmitted using automated methods for capturing and collecting surveillance and investigation data from healthcare providers.

**Ebola Mobile Application**

Public Health Preparedness along with the Office of Health and Risk Communication procured a mobile app to provide information to the public regarding Ebola. This app can

be used in the future for pushing out media information pertaining to various public health needs.

**Tuberculosis (TB)**

The TB clinics are in the process of procuring a mobile app to be used for Video Direct Observed Therapy. This will enable TB patients to use a smart phone to demonstrate that they are taking their medication as opposed to coming into a clinic to be physically watched by a public health nurse.

**Woman, Infant Children (WIC),**

The WIC program implemented Electronic Benefit Cards to be used by their clients, automating the old voucher system. In addition, the WIC program began a program to provide coupons to be used for purchasing fresh fruits and vegetables at local farmers markets.

**DPH Grants:**

A number of federally funded HIT-related grants fall under the jurisdiction of DHSS, including the Public Health grants in Table 2 below:

**Table 2. DPH Grants**

| Name | Public Law | Grant Type | Amount | Begin | End |
|---|---|---|---|---|---|
| ELC for Infectious Diseases & Epidemiology and Laboratory Capacity (ELC) Building & Strengthening Epidemiology Lab & Health Information (note: the previous ELC/ACA and ELC grants have been combined into one grant.) | ACA | Continuation | $1,558,828 | 8/1/2018 | 7/31/2019 |
| Epidemiology and Laboratory Capacity Grant – Supplemental Zika funding | | Supplemental | $435,759 | 1/1/17 | 7/31/19 |

| Name | Public Law | Grant Type | Amount | Begin | End |
|---|---|---|---|---|---|
| Immunizations and Vaccines for Children Grant | | Continuing | $1,787,492 | 7/1/2018 | 06/30/2019 |
| Development, Maintenance and Enhancement of Early Hearing Detection and Intervention Systems (EHDI-IS) Surveillance Programs | - | Continuation | $145,870 (Current Year Funding) | 7/1/2017 | 6/30/2020 |

**Epidemiology and Lab Capacity (ELC) Cooperative Agreement Program**

The grant continues to provide funding for the DPH use of the Rhapsody Server/HL7 Communications server. The grant has paid for upgrades allowing DPH to meet and support Meaningful Use Stage 1 & 2 requirements for our hospitals and providers.

**State Laboratory Systems:**

The ELC grant paid for the HL7 message engine allowing the Laboratory Information Management System (LIMS) to receive lab order requests from an EMR and send the lab results back to the requesting providers EMR. This capability will be leveraged to allow lab results to be sent to the DHIN to populate DHIN's community health record repository.

**Hospital Reporting:**

Delaware hospital systems are currently providing DPH electronic syndromic surveillance data via the DHIN. All Hospitals have upgraded their syndromic surveillance and electronic reportable Lab (ELR) data to the most current HL7 format and report through the DHIN on a daily basis. Delaware is receiving data from several Maryland hospitals as the DHIN expands its reach across Delaware borders.

**Immunization and Vaccines for Children**

The Immunization Information System (known as DelVAX) has continued to improve, adding yearly enhancements through collective funding with other Immunization Programs who use the WebIZ product. By pooling our resources, any improvements to the operating system are shared so that all users of WebIZ has the opportunity to share in every enhancement that has been created.

DelVAX has been hosted off-site since 2015, incorporated into the Microsoft Azure Government cloud, managed by the development vendor which has improved response time and better security.

Delaware is continuing to onboard providers to use HL7 messages, working in conjunction with the provider's EMR in order to provide quality HL7 messages that increases the quality of data within DelVAX. Immunization reporting numbers are on the rise as pharmacies and providers are sending electronic immunization data via Health Level 7 (HL7) protocol messages. In September of 2018, 99% of all Pharmacy immunization data is coming via HL7 messages, while 77% of all provider immunization data is coming via HL7.

Delaware has just completed a project with the City of Philadelphia to electronically exchange patient immunization data between their immunization information systems. The data exchange represents the culmination of a pilot program that has been ongoing for almost two years with the backing of the U.S. Department of Health and Human Services' (HHS) Office of the National Coordinator for Health Information Technology and HHS's Office of the Chief Technology Officer.

### 2..4.2 MITA SS-A

The Division completed a full MITA SS-A in November 2010. The MITA Business Process Model V2.1 was used to conduct the assessment. During the assessment, the MMLs were assessed and gaps were identified for business processes where the To Be MML was higher than the As Is MML.

During the SMHP planning phase, DMMA business area experts reviewed the regulatory requirements for submission of the SMHP published in the final rule at §495.332, and in CMS guidance for developing the SMHP published on April 29, 2010 and on August 17, 2010. The workgroups then reviewed each SMHP business process to determine if the standard MITA business process would apply to develop a concept of operations for the Delaware EHR Incentive Program. As shown in Figure 1 below, all MITA business processes were reviewed and where feasible the approach was adopted to integrate the Delaware EHR Incentive Program business process into DMMA's corresponding standard MITA business process.

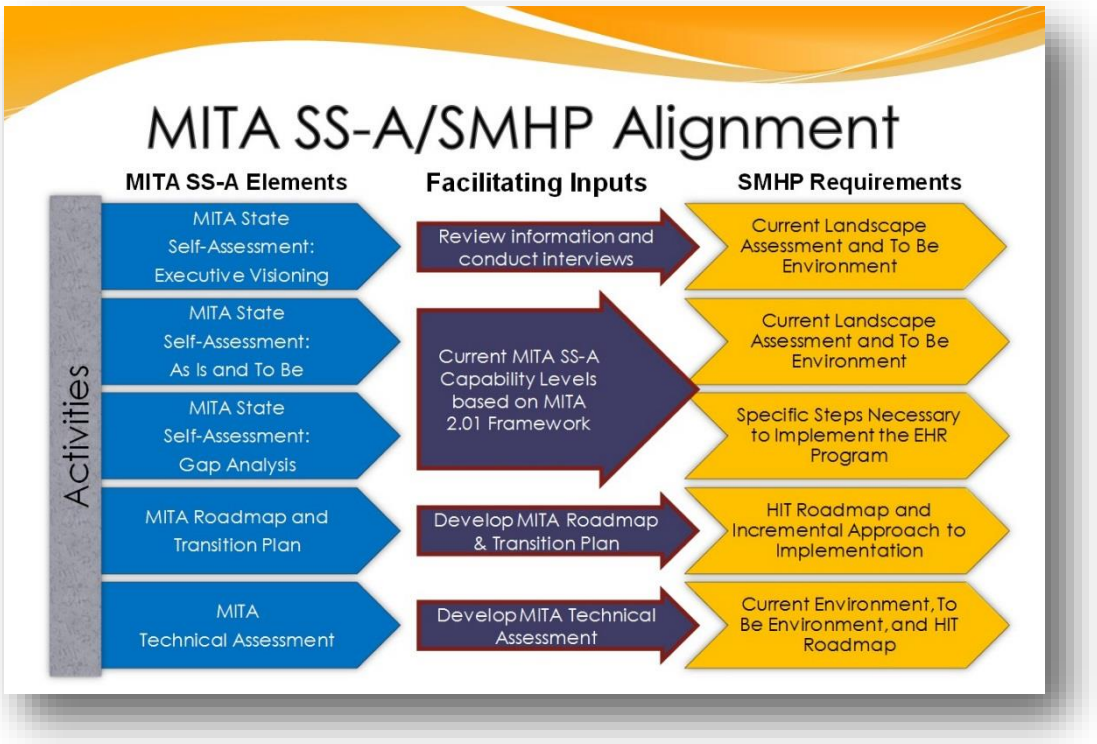



**Figure 1 MITA SS-A to SMHP Alignment**

Table 3 below lists the key Delaware MITA business processes that will potentially be used to accommodate the process changes needed to implement and operate the Medicaid EHR Incentive Program. This list is not intended to be an all-inclusive list of MITA business processes that the Delaware EHR Incentive Program will touch in some way (e.g., Manage 1099s will be touched without changes).

**Table 3 MITA Business Processes Impacted by Delaware EHR Incentive Program**

| Delaware EHR Incentive Program Process | MITA Business Process |
|---|---|
| 1. Verify that providers are not sanctioned, and are properly licensed/qualified providers. | • Enroll/Disenroll Provider<br>• Manage Provider Information |
| 2. Verify whether EPs are hospital-based. | • Enroll/Disenroll Provider<br>• Identify Candidate Case |
| 3. Verify overall content of provider attestations. | ▪ Enroll Provider |
| 4. Communicate with providers regarding their eligibility, payments, and other program issues. | • Manage Provider Communication<br>• Perform Provider Outreach |

| Delaware EHR Incentive Program Process | MITA Business Process |
|---|---|
| **5.** Calculate patient volume. | ▪ Enroll Provider<br>• Manage Provider Information<br>• Identify Candidate Case<br>• Edit/Audit Claim/Encounter<br>• Perform Accounting Functions<br>• Perform Provider Outreach |
| **6.** Verify patient volume data sources for EPs and ACHs. | • Enroll Provider |
| **7.** Verify the EPs at FQHCs/Rural Health Clinics (RHCs) meet the *practices predominantly* requirement. | • Enroll Provider |
| **8.** Verify *A/I/U* of certified EHR technology by providers. | • Enroll Provider |
| **9.** Verify *MU* of certified EHR technology for providers' 2nd participation year. | • Edit Claim/Encounter<br>• Identify Candidate Case |
| **10.** Propose changes to the MU definition, new/changes to State law(s). | • Develop and Maintain Program Policy (Note: Delaware does not intend to propose changes to MU definition)<br>• Manage Provider Information<br>• Manage Provider Communication |
| **11.** Verify providers' use of *certified EHR technology.* | • Edit Claim/Encounter<br>• Identify Candidate Case |
| **12.** Collect providers' MU data, including reporting of clinical quality measures. | • Manage Provider Information<br>• Manage Provider Communication |
| 13. Accept registration data for providers from Medicare and Medicaid EHR Incentive Program Registration and Attestation System (R&A System). | • Manage Provider Information<br>• Enroll Provider |
| **14.** Establish call centers/help desks and other means to address EP and EH questions regarding the Delaware EHR Incentive Program. | • Manage Provider Communication |
| **15.** Establish a provider appeal process (incentive payments, eligibility determination, A/I/U, MU). | • Manage Provider Grievance and Appeal |
| **16.** Assure that all Federal funding for incentive payments is accounted for separately for HITECH provisions and not comingled. | • Perform Accounting Functions<br>• Draw and Report FFP<br>• Manage FFP for Services<br>• Manage FMAP |
| **17.** Assure that Medicaid provider payments are paid directly to the provider without any deduction or rebate. | • Prepare Provider EFT-Check<br>• Perform Accounting Functions (Note—all payments will paid directly to providers) |
| **18.** Assure that provider payments go to an entity promoting the adoption of certified | • N/A—Delaware does not have paid entity promoting adoption |

| Delaware EHR Incentive Program Process | MITA Business Process |
|---|---|
| EHR technology, payment arrangement participation is voluntary, <5% retained for costs unrelated to EHR technology adoption. | |
| **19.** Assure that there are fiscal arrangements with providers to disburse incentive payments through Medicaid managed care plans. | • N/A—Delaware will not pay to managed care plans |
| **20.** Assure that all hospital calculations and EP payment incentives are consistent with statute and regulation (Note: EPs are based on calendar year (CY), EHs are based on federal fiscal year (FFY) because of reporting). | • Perform Accounting Functions<br>• Manage Payment Information<br>• Price Claim/Encounter<br>• Manage Recoupment |
| **21.** Identify suspected fraud and abuse. | • Identify Candidate Case<br>• Manage Recoupment |
| **22.** Track the total dollar amount of overpayments identified by the State as a result of FFY oversight activities. | • Manage Case<br>• Perform Accounting Functions<br>• Manage Recoupment |
| **23.** Take action when fraud and abuse is detected. | • Manage Case<br>• Manage Recoupment |
| **24.** Perform audits. | • Identify Candidate Case |

In preparing for the DMES DDI, CMS encouraged DHSS to connect the MITA 3.0 assessment to the DMES procurement. DHSS was approved to perform the MITA 3.0 assessment as the first phase of DDI. In April 2014 DMMA submitted Delaware's MITA 3.0 State Self-Assessment (SS-A) to CMS. The MITA 3.0 assessment occurred in conjunction with the development of DMES. MITA Business processes impacted by Delaware EHR Incentive Program did not change as a result of the assessment. A number of MITA SS-A themes were identified in performing the analysis that mapped to general organizational and process improvements. DMMA prioritized the business area improvements and created a high level wish list to be eventually considered in tandem with the MITA SS-A To Be Assessment results. The resulting initiatives that would increase MITA maturity included the development of a Data Warehouse (DW) and Decision Support System (DSS). The DW/DSS will provide Predictive Analytics capabilities to prevent and control fraud, waste, and abuse in health and human services; provide tools to analyze Medicaid benefit policy, including provider payment reimbursement policies, inconsistencies, as well as errors or needed enhancements within the claims processing and related system. Additionally, the system will provide DHSS with tools to measure clinical quality for improved program management. DHSS will also use the tool to ascertain the impacts of changes related to International Classification of Diseases, Tenth Revision (ICD-10) conversion and Affordable Care Act (ACA) compliance.

### 2..4.3 MMIS Environment after DMES Implementation

DMMA brought into production a new Medicaid Management Information System called the Delaware Medicaid Enterprise System (DMES) on January 1, 2017. The CMS Seven Conditions and Standards released April 19, 2011, require an MMIS that embraces a modular framework using a Service Oriented Architecture (SOA) and complies with the Seven Conditions and Standards set forth by CMS policy document. MITA 3.0 SS-A is occurring in conjunction with development of DMES. The incumbent FA contract extension ends on June 30, 2016 but was extended to accommodate the DMES Go-Live date of January 1, 2017.

DXC is the Medicaid FA for the DMMA and manages the MMIS and is also the manager for the new DMES. The MMIS is connected with providers and business associates through a variety of interfaces. DXCS delivered the interchange solution to allow DHSS to move beyond simple claims processing and shift its investment to implementing more mature business processes that deliver additional value to Delaware. The DXC Technology team delivers these services with honed experience and innovative thinking, a certified MMIS solution, CMS- and MITA- aligned processes and tools, and unparalleled project management experience developed during many years of Delaware Medicaid implementations and process improvements.

DXC developed the HP interChange Healthcare Platform with the flexibility to address current and future interface requirements. Multiple transaction formats such as X12, NCPDP, and proprietary formats are routinely and successfully exchanged in states where the interChange solution has been implemented. The interChange Connections module of the DMES will accommodate the exchange of data with internal and external entities using the media that is appropriate to each exchange. With HIPAA security and data protection rules in mind, DXC has successfully developed and operates web-based interface applications in which providers can securely upload and download files and allow operations staff members to initiate a secure file exchange with CMS.

To determine the best approach, DXC focuses on the best solution for each interface Delaware requests. Some interfaces—such as the standard CMS, X12, and NCPDP exchanges—will require minimal DHSS input as DXC has implemented these exchanges for each interChange state and has addressed the current HIPAA requirements. The interfaces for the formal healthcare transaction sets will be performed through the interChange Connections EDI solution. Additionally, DXC will work with DHSS to determine what proprietary file formats and Delaware-specific interfaces will need accommodation and recommend the most appropriate transfer method. The interChange MMIS solution will provide comprehensive interface capabilities required to support the stakeholders who have direct data interaction with the MMIS.

The details of the approach include using the interChange Connections capabilities, using secure FTP (SFTP) and the MMIS SOA as a key DMES interface solution. The integrated architecture made possible through the Connections module is responsive, resilient, and reliable. DHSS will gain better visibility into enterprise information and quickly adapt applications to changing business processes. The Connections module supports EDI processing for claims, eligibility, prior authorization (PA), point of service (POS), providers, and managed care

organizations (MCOs) and the other interfaces needed to operate the MMIS transactional processing system.

The DXC interChange database architecture, based on Oracle, has proven to scale to some of the largest states in the union. DXC has nine current MMIS customers operating in the Orlando Data Center, and Delaware will join them. DXC's database architecture's backup and disaster recovery architecture has been tested dozens of times in annual disaster recovery drills.

DXC will be using Computer Associates' (CA's) ERwin to develop the conceptual, logical, and physical models produced in this project. ERwin separates the logical and physical data model designs, a feature that supports a business and a technical view of the proposed system. This allows nontechnical users to better understand the underlying data associated with business processes and functions, and to validate the data requirements needed for these functions.

DXC will rely on two relational database management systems as part of the system architecture. interChange uses Oracle for its proven and reliable, online transaction processing (OLTP) capabilities. DXC MMISs have used Oracle for almost 20 years. DXC also includes Microsoft SQL Server in two specific architectural roles. The first is to support other Microsoft applications including BizTalk and SharePoint. The second is to serve as the online analytical processing (OLAP) foundation for advanced capabilities used for inSight Dashboards and the interactive analytical features they provide.

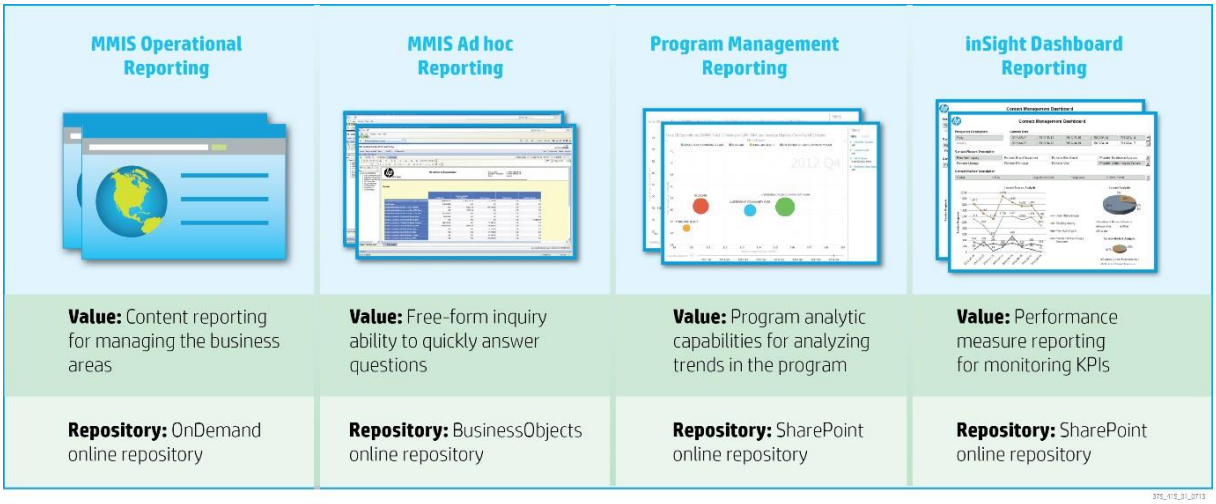
The new DMES is based on the current release of the Oracle relational database management system (RDBMS) - 11gR2 or newer, and Microsoft SQL Server 2008 R2 or newer.

DXC' multifaceted reporting solution offers standard operational reports for routine use, ad hoc reporting for special needs, and a true visual dashboard for providing current metrics on key performance indicators.

Delaware state executives, program managers, and analysts need quick and easy access to retrieve and analyze Medicaid program data on demand. There is a continual need for current and reliable information. As the volume and breadth of the data is increasing, the need to query, analyze, evaluate, and meaningfully report the data has never been greater.

There is valuable knowledge contained within the vast amounts of data that healthcare payers collect and manage. Data must be transformed into knowledge to be fully actionable and of high value to decision-makers. The ability to make timely and informed decisions about program aspects ranging from eligibility to policies to reimbursement methodologies is vital to the health of Delaware residents and the Delaware Medicaid Program. The illustration below provides an overview of the four components of the DMES MMIS reporting and analytics solution.

**DMES Reporting and Analytics**




It is important to have the right information in the right format. This is vital to the success of any MMIS. DMES provides the option for a comprehensive MMIS Report and Analytics Management System that comprises the following features:

- **MMIS Operational Reporting—**Each business area of the MMIS has reporting required by both the state of Delaware and Federal laws. The standard operational reports are used for the management of the transactional MMIS business functions.
- **MMIS Ad Hoc Reporting—**A centralized ad hoc data repository and specialized reporting data model will be available at the detail claims level giving ad hoc access to MMIS data elements using the BusinessObjects Web Intelligence toolset. The key differentiator of DXC Ad Hoc Reporting environment is access to more data elements than any other niche reporting vendors. The interChange ad hoc has an easy to use toolset that provides the ability to ask program questions and get data that can be turned into informed decisions quickly on the user's desktop.
- **inSight Program Management Analytics—**DMES exceeds the federal reporting requirements of CMS both for T-MSIS and CMS 372 reporting, through online, parameter driven reports for items such as Provider Participation, Member Enrollment, Claims Throughput, and Error Code Analysis. These reports provide intuitive operational reporting that help support daily activities while providing guidance for improvements in policymaking and operations.
- **inSight Performance Dashboard Analytics—**Presents visual, interactive dashboards of Key Performance Indicator (KPI) Metrics to support executive decision-makers' daily activities. Insight dashboards and ad hoc reports using the Microsoft Business Intelligence (BI) Tools empower users to make informed business decisions while providing new

technologies for building and storing large data sets in memory for detail level reporting on millions of records.

### interChange Reporting and Analytics Architecture

The interChange solution segments the reporting architecture from the transactional processing architecture to avoid affecting the MMIS business processing and to make report generation easier. The reporting data stores are separated from the transactional data store to provide the right data in the right format at the right time. This includes:

- Daily, weekly, monthly operational reports to manage the business functions
- Business Activity Monitoring (BAM) reports for the MMIS workflow processes
- Ad hoc support from a broad set of MMIS data attributes
- Performance management dashboard analytics
- Pharmacy analytics for online interactive analysis of pharmacy utilization
- Industry-Based, Open Architectural Standards
- DHSS's solution is a standards-based approach to healthcare architecture; the new DMES is based on the CMS-certified HP interChange Healthcare Platform and the new DMES is based on MITA designs. The core solution is based on early adoption of MITA principles with enhancements that enable continued process maturation. The evolution of the HP interChange Healthcare Platform aligns with MITA's published Architecture Framework standards and requirements This solution emphasizes the MITA-aligned architecture and business processes required for DHSS. MITA itself does not dictate a specific technology policy, just the required technical capabilities. This guidance will enable the new DMES to be extended to encompass DHSS's customized needs and still support the MITA requirements.

**Key features of the new DMES will include the following**:

- A **robust provider and client portal** that offers a one-stop access point for information-gathering. The proposed portal will allow for more information to be readily available at the click of the mouse for prompt delivery and continual availability of the most current information. The new DMES portal will be a powerful tool for the provider and client communities. The portal and its functional capability have literally changed the way providers conduct business with Medicaid.
- An **enhanced provider enrollment process**, combining workflow processing and automated screenings and background investigations processes, streamline the enrollment process. The provider enrollment process uses a blend of COTS products and proven Medicaid-specific components used successfully with our other state customers. The COTS products and transferred components are integrated to automate business processes that historically are manually intensive and disjointed.

- **DMES screens were built and organized by MITA business processes**, allowing DHSS to easily adapt to the evolving MITA maturity path.
- **@neTouch** is one of DXCS' newest rounds of innovation, a family of features designed to streamline working with the new DMES. Accurate, accessible, and easily maintainable reference data is the critical link between the new DMES and state healthcare policy. Users can apply and maintain complex policies with maximum efficiency, exceptional productivity, and personalized flexibility.
- **Innovative workflow tools** that will allow users to see each step in a business process and a historical view of specific steps that are performed within a workflow, providing information in dispute resolutions. This approach to workflow management transforms the work task experience.

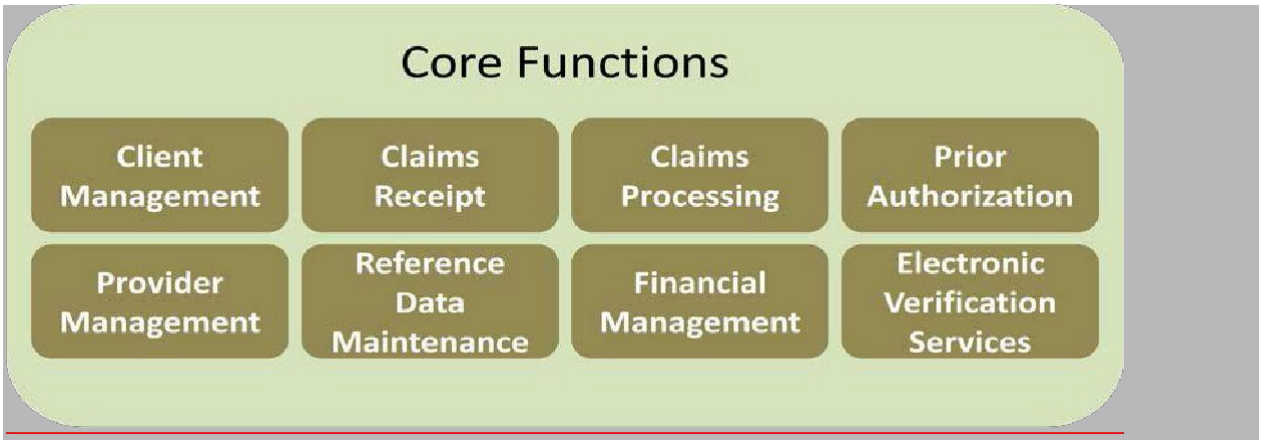
### Technical Components

To complement the new DMES, the solution will include key technical components, including COTS, which will advance and improve our business processes. These components will include the following:

- **Contact Tracking Management System**—Comprehensive service desk system will track interactions with providers including telephone calls, on-site visits, and correspondence. As part of the CTMS, a quality assurance and work force management tool will be offered that will confirm the workload is effectively managed and monitored.
- **Voice Response System (VRS**)—Self-service features of the Healthcare Provider Portal, providers can obtain eligibility information and check claims status through the automated VRS feature of the call center. This service will be available 24 x 7.
- **Electronic Document Management System (EDMS**)—EDMS will be used to store claim and correspondence images for electronic or hard-copy claims. This tool also will store provider correspondence. Its online query tools will give users immediate access to letters generated to a given provider.
- **Letter Generator** – interChange will use our letter generator tool to auto-generate letters in response to provider inquiries and send them to the mailroom for prompt mailing. Letter Generator uses standard templates for routine correspondence such as acknowledgment letters but allows for customized letter creation such as Erroneous Processing Corrections (EPCs) or other special provider communications.

### Core Functions

The Core Functions area includes many of the traditional MMIS fiscal agent activities. The areas encompass a broad range of activities including client, provider, claims processing, and payment functions.




## Client Management

The new DMES offers a robust solution for maintaining accurate client demographics and enrollment eligibility information:

- An innovative web-based DXC Client Healthcare Portal will enable DHSS clients to access important information about their healthcare benefits, options for doctors and treatment facilities, and much more.
- The DXC Client Healthcare Portal also facilitates communication with clients and keeps them updated on program changes, appeals process, and other outreach and educational needs DHSS defines. The DMES Client Management business area will generate multiple types of communications including appropriate approval, pending, and denial notices to providers or clients including denial reason, grievance and appeal rights, and procedures as part of the automatic update processes. These notices are generated from the correspondence management component, Letter Generator.
- Interaction with the clients or providers by using the call center will be tracked using the new DMES Call Tracking Management System (CTMS) module.
- Client paper documents are stored in the Electronic Document Management System (EDMS). For example, when medical questionnaires are received by the DXC mailroom, they will be, scanned, and stored in the EDMS and indexed to the appropriate client or provider.

## Provider Management

A feature-rich provider management system is critical to successful provider operations. The DMES solution offers a more streamlined enrollment process. It offers innovative tools that give providers more information at their fingertips and allows operational staff members to manage provider data and assist providers more effectively through intuitive web-based screens.

The principles on which interChange is founded will move DHSS forward in its pursuit to use innovative and proven business solutions to meet ongoing program demands while continuing to deliver high-value services. This easily configurable system is based on a service-oriented architecture (SOA) platform and allows COTS products to be installed easily, integrated, and updated as deemed necessary by DHSS. DMES includes more efficient and streamlined automated processes that have the flexibility to adapt and change to fit DHSS's needs. The solution provides the following features:

- A robust provider portal that offers a one-stop access point for information gathering
- An enhanced provider enrollment process, combining workflow processing and automated background investigations to streamline the enrollment process
- Web pages built and organized by MITA business processes, allowing DHSS to adapt easily to the evolving MITA maturity path
- @neTouch Help, which indicates the definition of every field on the web page, their related data type and format, and edits and validations that are performed
- Innovative workflow tools that allow users to see each step in a business process and a historical view of specific steps that were performed within a workflow, providing information in any dispute resolution

### Reference Data Maintenance

The new DMES will subject claims to automated system edits and audits to verify that they comply with Delaware Medicaid policies and medical criteria:

- Validity editing of claims is a part of the new DMES and will edit against the provider, client, and reference data tables as part of the claims processing function. The system edits claims and encounters against the provider, client, and reference data files as part of the claims processing function. The MMIS edits each claim or encounter as completely as possible during an edit cycle rather than ceasing the process when it encounters a failure so that multiple resubmissions of the claim are not required. During editing, the claims processing system accesses various files to validate the claims data.
- The reference data business area provides a reliable, configurable, flexible means to maintain information required by DHSS for claims administration and transaction processing. The primary function of the reference tables are to serve as the repository of data and business rules required for prior authorization determination, claims adjudication and pricing, edits and audits. Code sets within reference support various management, ad hoc, and utilization reporting functions. The reference tables provide an integrated method of storing MMIS reference data and allow for centralized control and an audit trail for table value changes.

- Reference data provides authorized users the flexibility to update data tables through the new DMES panels and administer Delaware Medicaid Program policies.
- The new DMES presents EOB and denial reason descriptions in language that is easy to read.

### Claims Receipt

Accurate claims receipt and adjudication processes are fundamental to a successful Medicaid program. DXC processes more than 22 million claims per year for DHSS, so the new DMES must adjudicate claims effectively and efficiently. The Delaware Medicaid electronic claims submission model has proven to be extremely successful—today, approximately 98 percent of claims are submitted electronically. The number of paper claims is primarily limited to those that providers must bill on paper because of timing issues or attachment requirements

### Claims Processing

Payment rates will be at the core of DMES claims processing. The process of adding new programs and rates is table-driven, allowing DHSS to expedite implementation of new programs or rates without experiencing the costs and time delays typically involved with a system development and installation project.

The new DMES will allow trained, authorized users to identify, create, refine, and maintain business rules that effectively capture and enforce medical policy, including rates. Within the new DMES, various business rules will govern each claim processed—billing rules from policy and contracts, coverage rules from benefit plans, and reimbursement rules that will determine how to price and pay the claim. The disposition of edits associated with business rules will determine whether to pay, suspend, or deny claims according to DHSS policy on how to adjudicate each service.

As healthcare continues to change, DHSS must have the technical and operational support necessary to take a code set from receipt to program inclusion such as Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), International Classification of Diseases (ICD), National Drug Code (NDC), Current Dental Terminology (CDT), or revenue codes. The overall reference data management provides an efficient, structured process for managing complex healthcare policies for accurate claims processing.

An audit trail tracks reference file updates to support the Delaware Medicaid Program and is available for DHSS review. Additionally, updates are end-dated, not deleted, preserving the data integrity while archiving historical information for claims processing and DHSS reference.

The new DMES enables users to suppress claims processing based on criteria determined by DHSS. Post-claims processing can hold the claim. For example, if a client's ID is changed to reflect a new plan, the claim needs to be adjusted but not paid again. The new DMES can create a new claim with the new client's ID behind the scene, which is not apparent to the provider.

BPA rules are responsible for most claims adjudication, pricing, editing, and auditing decisions. The configurability built into the BPA rules will give DHSS the flexibility and scalability to use the new DMES for pre-adjudication transaction processing for multiple programs across the enterprise.

The BPA rules engine defines and processes the following rule types:

- **Provider contract rules—**What services a provider is allowed to perform
- **Client plans rules—**What services a client is eligible to receive
- **Reimbursement rules—**What decisions on appropriate pricing methodology to apply
- **Assignment plan rules—**What services to carve-out of a capitated managed care plan
- **Edit rules—**Most edits that are rule-driven through configuration
- **Audit rules—**Most audits that are rule-driven through configuration
- **Copay rules—**Client responsibility amount
- **TPL rules—**What services are covered by carrier-specific rules allowing cost avoidance and recovery

### Prior Authorization

Portal users who have been granted access to prior authorization information have a wealth of data available to them through advanced search capabilities. Users can see the detail of an individual prior authorization and listings of submitted prior authorizations based on the search criteria entered:

- The View Authorization Status page of the HP Healthcare Portal allows providers to view at a glance the status of their authorizations on a real-time basis, as requests are being processed.
- Information shown in the summary page includes client ID, tracking number, authorization type, authorization service dates, status, requesting provider, and servicing provider. Portal users may select a specific authorization in the summary list to view details, including diagnosis information, remarks/notes, and the number of remaining units for a given approved service line based on claims activity.
- Users can create and view a PDF of submitted prior authorizations. The PDF may be printed or saved for future reference.
- Users also can see a PDF version of a prior authorization as soon as it is submitted.

### Financial Management

The DMES will include an enhanced financial management business system providing an IT solution supporting DHSS' business requirements. The proposed DMES solution includes a flexible financial management business system meeting the changing needs of Delaware's dynamic Medicaid program and the changing and demanding needs of CMS 7CS including MITA.

- The new DMES solution is compliant with Generally Accepted Accounting Principles (GAAP), federal and State rules, and regulations, and provides the internal controls necessary for continued Sarbanes-Oxley compliance. The integrated solution provides the flexibility to track and report Delaware Medicaid Program transactions across the multitude of formats and structures needed to effectively manage and report the financial operations of every health program administered by the State.
- The fully integrated DMES links transaction detail—such as claims, adjustments, payments, receivables, cash receipts, recoupments, and voids—to related records and the various levels of detailed reporting the State requires. The requisite internal controls enable accurate financial reporting on actual performance and an integrated module for forecasting of budgeted expenditures.
- Our solution provides encompassing system support to the finance environment, including provider accounts receivable, electronic remittance advices, audit trails on the claims history file, and tracking of financial transactions by source.
- The solution includes reporting capabilities for payments made, overpayment tracking, program data, key performance indicators, and operational reporting.
- The new DMES supports established and future reconciliation processes by enabling research and resolution of data discrepancies. The Financial Operations team uses experienced staff members and various financial reports to account for issued items and validate balances after every payment cycle.
- The new DMES solution provides extensive online audit trail capability. If data is changed, this audit trail also shows the originally entered data and the data that was changed. From the time a transaction enters the financial processing system, the new DMES tracks it as it moves through final resolution.

**Electronic Verification System (EVS)**

Central to the new DMES solution is the interChange system, a powerful engine that stores client, provider, stakeholder, and transaction information. Our solution allows providers the flexibility to submit transactions through one of three methods:

- **Voice Response System (VRS)**—Providers can perform inquiries through the DMES VRS.
- **HIPAA-compliant web-based provider portal**—Providers can perform inquiries through our HP Healthcare Portal, which provides more features than the current EVS.
- **Vendor software**—Providers can continue to use their existing vendor systems to submit transactions as they do today.

The biggest advantage the new DMES offers providers for claims submission is real-time adjudication. Today, the MMIS mostly performs front-end editing only, with a few exceptions. The new DMES adjudicates claims in real time, allowing providers to know what their expected payment will be.

## 2..5 Environmental As Is Scan

Delaware developed a State Health Care Innovation Plan to transform our health care system, with support from the Center for Medicare and Medicaid Innovation (CMMI) State Innovation Models (SIM) initiative. Ambitious goals for improving health care for Delawareans and improving the sustainability of our health care system have been developed, and are supported by a broad set of stakeholders who are committed to making real and lasting change including physicians, hospitals, other providers, insurers, businesses, consumer advocates and our education and research community. The goal is the "Triple Aim" - improving the health of Delawareans, improving the patient experience of care, and reducing health care costs. Through the SIM initiative, Delaware is planning to build upon a strong local foundation for innovation in order to achieve this through a system-level transformative healthcare plan that can serve as a scalable model for the nation. The goal is to develop and implement a plan for broad-based health system transformation, including new payment and delivery models, which will achieve the Triple Aim. Delaware has been awarded a "Design" grant through the CMMI SIM initiative to provide funding as we develop our State Health Care Innovation Plan. In December of 2014, Delaware received a $35 million SIM “Testing” grant to build and implement its State Health Care Innovation Plan. The following is the State Innovation Model Operational Plan for Model Test Year 3 (Award Year 4) for the period February 1, 2018 – January 31, 2019:

This year’s work plan is centered on Healthy Neighborhoods, payment reform, behavioral health integration, and others –all supported by Health IT—and continue our efforts to transform health and health care for all Delawareans.

- Payment reform and related activities will be a major focus of our work this year. The Health Care Commission (HCC) will continue to support the Department of Health and Social Services in their efforts to construct and launch a health care benchmark. New models for payment will be developed in collaboration with Delaware payers, providers, and consumers. The HCC and its vendors will also continue to forward transparency and quality efforts through payment reforms on many fronts—linking with DHIN and the practice transformation efforts under SIM.
- Behavioral health integration will be the backbone of our practice transformation work. Founded on the plan developed in AY3, HCC will work with practices across the state to improve their capacity to address behavioral health needs alongside primary care. The HCC will also continue to support other practice transformation activities, and seek ways to support provider engagement in Delaware’s Health Information Network (DHIN).
- Our Healthy Neighborhoods initiative was launched in the fall, and will propel population health efforts through the three county-based HN councils. In this year, the HCC will conduct a mini-grant program that allows these local councils to implement critical, evidence-based programs to improve population health. The HCC will also support

population health through several other consumer-based efforts, including the state employees' programs and elsewhere.

- Health IT and health information exchange and transparency underpin the success and sustainability of all of these efforts. Without data, payment reforms can be lop-sided, practice transformation can be stymied, and local communities cannot target high-need issues and populations. Therefore, the HCC will continue to work with DHIN and invest in our HIT efforts—in concert with our other initiatives.

These four lines of work are of critical importance to the state of Delaware in achieving transformation. But they do not exist in a vacuum. Therefore, the HCC is working to closely manage and integrate across these initiatives, and to ensure a coherent program of work that facilitates improvement. Furthermore, the Health Care Commission will use this final year of the SIM grant to look forward and plan for the future. Our payment, practice and community transformation efforts will get the ball rolling across the state, but we must all work together to keep that momentum. We believe this plan sets the stage for Delaware to ultimately reach our SIM goal: The Triple Aim Plus One.

DHIN is the state-sanctioned provider of HIE services for Delaware, and is the only HIE currently operating in the State. The Delaware Health Information Network (DHIN) played an important role with the SIM Testing grant in developing and supporting the common provider scorecard, which will standardize the quality indicators used by payers to determine reimbursement rates for providers.

### 2..5.1 Key HIT Activities in State

Below is a detailed description of the variety of statewide activities in Delaware that affect or are related to HIT.

### 2..5.2 Broadband Internet Access

Delaware boasts some of the fastest Internet connection speeds in the country and ranks among the fastest in the world according to Akamai Technologies Inc., which publishes a quarterly "State of the Internet" report. Downloading a high definition movie that would have taken 25 seconds in 2009 can be accomplished in about 2 seconds on today's network.

Delaware, with a 25.2 Mbps average speed, joined the District of Columbia for the first time in surpassing the FCC's 25 Mbps broadband threshold.

In 2014, Delaware had the largest increase in Internet speed of any state in the nation with a 42% jump over the previous year.

Delaware's Department of Technology and Information manages Wi-Fi networks in more than 200 state government buildings, which provide fast and reliable access to more than 2,500 staff and citizens each day.

Since 2009, public-private partnerships to expand Delaware's broadband infrastructure have resulted in construction of more than 700 miles of new fiber optic infrastructure throughout the state.

Delaware's broadband "backbone" features high capacity fiber-optic lines that run the length of the state from Wilmington to Georgetown, and from Seaford to Lewes, improving internet reliability

for consumers and increasing internet access speeds by as much as 10 times since 2009.

Legislation passed in 2013 establishing the Delaware Broadband Grant allows DTI to leverage additional private investment to install high speed fiber optic lines in underserved communities and key public sites such as schools, libraries, health care facilities, and places that provide government services.

Work with wireless service providers to expand and upgrade 4G/LTE cellular phone services into southern and rural communities across Delaware has ensured more than 99 percent of the state is covered by wireless providers, improving citizen access to public safety and emergency services, including enhanced 911, benefiting the agricultural community, and improving services to local businesses.

HB 189, signed into law by Governor Carney on August 31, 2017, the "Advanced Wireless Infrastructure Investment Act," creates a new Chapter 16 of Title 17 that will accelerate investment in mobile broadband infrastructure and ready the state for the next wave of economic development in the digital economy. In recognition of the shift from landline to wireless communications, the Act authorizes wireless providers access to the state's rights of way and establishes a statewide policy for deployment of small wireless cells to meet the growing demand for wireless services which provide Delaware citizens with access to advanced technology, information and 911 services. The measure streamlines the permitting process and includes other provisions that will expedite the installation of "small cell" wireless infrastructure.

**Wireless Broadband Access Expansion for Sussex County – April 2018**

Governor Carney's Support for Wireless Broadband Access - The Action Plan for Delaware is very clear: the Governor views broadband as a key player in support of economic growth and development, education, and public safety initiatives. The Plan highlights 2 priorities: identification of Delaware's broadband deserts, and expansion of broadband Internet access in under-served areas of the state. To send a clear and public message that this is high on his list of priorities, the Governor is planning a tour to highlight broadband's importance.

**Broadband Expansion Challenges**

• Cooperative vendor agreements expanded fiber availability: 48 schools upgraded to high-speed connections, but rural fiber is not economical.
• Affordable wired broadband is still out of reach of rural K12 students in Laurel, Lake Forest, Delmar and Woodbridge where access beyond 10 Mbps is rare.
• Significant broadband deserts exist in Kent and Sussex Counties. These counties rank 249th (Kent) and 428th (Sussex) nationwide (2014), with only 63.3% and 57.8% respectively, subscribing to wired broadband.
• Some Delawareans have limited (or nonexistent) access options for affordable broadband services.

**Broadband Grant Phase II - Wireless**

As wireless broadband solutions offer increasing speed and reliability, rural households and businesses have opportunities to leapfrog over previous technological solutions, just as some developing countries skipped landline telephones in favor of mobile technology. Phase II

Delaware Broadband Fund Grant Project awards incentivize fixed wireless broadband and municipal wireless broadband projects in under-served communities in Kent and Sussex Counties. Phase II pilot funds support two fixed wireless pilots (Seaford and Marydel) and one municipal wireless pilot (Rehoboth Beach). Working with Bloosurf (fixed wireless grantee), DTI, in its grant administrator role, facilitated Bloosurf's leased use of the Division of Communications' (DivComm) Seaford tower for the Seaford pilot. Through this relationship, an opportunity was identified to address all of Sussex County's broadband access deserts by making strategic use of existing state technology assets.

### 2..5.3 Beacon Community Grant

Delaware does not have a Beacon Grant recipient.

### 2..5.4 Health Resources and Services Administration (HRSA) Grants

HRSA grants in all counties of Delaware can be found at http://granteefind.hrsa.gov/. Although the grants do not have a HIE component at this time, they are being reviewed for how DHSS, the Delaware EHR Incentive Program, and DHIN can best leverage these projects in support of HIT/HIE efforts.

### 2..5.5 State HIE

**Delaware Health Information Network**

The Delaware Health Information Network (DHIN) is a not-for-profit instrumentality of the State of Delaware with the statutory purpose to develop and operate a state-wide health information network integrating clinical, financial, and patient satisfaction data sources to inform decisions (16 Del Code § 10303). Expected benefits are improved communication within the healthcare community, improved efficiency and elimination of redundant testing, monitoring of population health and community health status, reduction in healthcare costs, and serving as the trusted source of information for consumers and purchasers as well as providers of care. DHIN is governed by a public-private board which includes individuals with various business, technology and healthcare industry skills committed to managing the Corporation in an efficient, effective and competitive manner. 16 Del. C. § 10302. DHIN is the state sanctioned provider of HIE services, and is the only public HIE in the state of Delaware.

**Current DHIN Services and Capabilities:**

DHIN-to-EHR Integrations

As a special instance of Electronic Clinical Results Delivery, DHIN can interface to any electronic health record (EHR) capable of connecting via a web-service interface using Health Level Seven (HL7) standard language. The advantage of such an integration over other forms of results delivery is that the end user requires no special effort or actions to receive their results – they are delivered automatically into the EHR and accessible in the normal workflow of the user. Once DHIN certifies that a single interface to DHIN pulls all data types from all data senders and these results are stored and displayed correctly in that EHR, the vendor is free to market it as a DHIN-certified results delivery interface and sell it to all their clients who are DHIN members. There are currently certified results delivery interfaces from DHIN to 26 EHRs, representing 76% of EHR users in the state.

Single Sign-On (SSO)

A user experience pain point for providers has been the necessity to authenticate into multiple systems while in the same user interface. DHIN partners with EHR vendors to solve this problem by allowing seamless access into the DHIN Community Health Record, using the authentication credentials of the EHR system.

Care Summary Exchange

Providers and practices using certified EHR technology (CEHRT) are able to send to DHIN a summary of care using the C-CDA standard following each ambulatory visit. DHIN makes these available for viewing within the CHR as an additional data type, and provides reports to the sending practices on the number of views of this data for purposes of Meaningful Use reporting. DHIN will also shortly be making these summaries available to patients who enroll in the state-wide PHR/patient portal and provide Meaningful Use reporting to the sending practices on a range of consumer engagement objectives. DHIN is currently exploring the feasibility of using these care summaries as the source for clinical quality reporting on behalf of the sending organizations. At this time, approximately 13% of Delaware ambulatory providers have subscribed to this service.

Clinical Gateway

For organizations which already have analytics tools and just need the data, DHIN is able to match incoming data from all sources against a watch list of patients provided by a subscribing organization and route a copy of the data to that organization, thus permitting them to apply their own tools for analysis. Large health systems can utilize this valuable data in support of their population health initiatives.

Community Health Record

All clinical data from all data sending organizations is aggregated into a composite longitudinal record for each patient. This record can be queried by properly privileged users for both previously unknown patients and unknown data about a known patient. This aggregated view of the patient across geography, time and care settings is core to DHIN's value proposition. The Community Health Record contains health data on nearly all Delawareans, as well as patients from all 50 states. In addition to information from Delaware facilities on Delaware patients, DHIN also receives information on Delaware patients from providers/facilities in other states.

Out-of-State Connections:

DHIN and the Maryland state HIE, Chesapeake Regional Information System for Our Patients (CRISP) exchange ADTs based on the state of residence of the patient. CRISP also provides the infrastructure for HIEs for Washington, DC and West Virginia, which enables DHIN to receive ADT data on Delawareans who receive care in any of these markets.

DHIN also exchanges information with NJSHINE, the HIE covering the southern counties of New Jersey, for similar exchange of ADTs based on state of residence of the patient.

Event Notification System

DHIN uses the ADT data coming from Delaware, Southeastern Pennsylvania, New Jersey, Maryland, West Virginia, District of Columbia, and Ohio hospitals, emergency departments, and participating walk-in clinics to match against a watch list of patients for whom a subscriber wishes to receive notifications. Notifications can be delivered real time or batched for delivery at intervals of the user's choice. Forty nine percent of Delaware residents are covered by a health plan using this service for purposes of outreach and care coordination. Approximately 17% of Delaware's ambulatory health care providers have also subscribed to this service for purposes of care coordination and transitional care management.

API to DHIN clinical data for use by their PHR

Many hospital systems and other data providers offer a Personal Health Record (PHR) for use by their patients to view information generated by the given health system. Typically though, the patient is only able to see information created by that health system. As a result, the patient is only able to see a limited amount of information, and if the patient wants to see more of their information, they would need create credentials and log in to another PHR system, creating frustration and dissatisfaction for the patient. DHIN offers the ability for the hospital to create an Application Program Interface (API) which links the hospital's system to DHIN's data repository and provides the ability to send patient information from all of DHIN's 26 primary data providers and out of state ADT providers to the hospital's PHR system so that the patient can view all of his/her information within the hospital's PHR setting, thereby creating hospital loyalty by the patient as they can view all of their information in that hospital's PHR system. In addition, patient satisfaction increases as he/she no longer needs to go to multiple PHR systems to obtain their information.

Care Summary Creation and Download

As part of the Community Health Record, DHIN provides the ability to create a Continuity of Care document (CCD) from within the DHIN Community Health Record which includes all data from all data senders. The user may apply filters to limit the date range or specific data types to be included in the composite CCD. The resulting document may then be downloaded to the user's local environment, either in a pdf format, or as structured data if their EHR has the ability to consume it as such. Thus, even without an integration between DHIN and the user's EHR, the capability exists to incorporate data from the Community Health Record into the user's EHR and make it a part of their local record of care.

Statewide Patient Portal/Personal Health Record (PHR)

Because DHIN receives data from many sources, it is uniquely positioned to provide patients/consumers with access to their personal health data with minimum effort. For practices that have already implemented a patient portal, an API connection to the DHIN data repository allows data from all sources to be retrieved and presented upon patient login to the hospital or practice portal. For those who have not yet implemented a portal, DHIN offers a co-branded implementation of the tool we are calling "Health Check Connect." This not only provides access to the data in the DHIN data repository, but offers additional features and functions, to include secure messaging between providers and patients, patient education resources, and interfaces to various medical devices, such as digital scales, glucometers, blood pressure measuring

devices, exercise/activity trackers, and others. The patient will have the option to select their language preference when they set up their account. At launch, supported languages will be English, Spanish and Romanian, with plans to add others as fast as translators can be found to assist with the mapping.

Medication History

This is a value-added subscription service which allows a user of the CHR to retrieve 12 months of prescription fill history (provided by a number of national sources, to include SureScripts, health plan pharmacy benefits managers, and others) upon demand. For those who do not choose to subscribe to the full service, there is a URL link embedded in the DHIN web portal that takes the user to the Delaware Prescription Monitoring database, where they can at minimum (and for no charge) view the controlled substance fill history for the patient.

PACS Image Sharing

St Francis Hospital, Mid-Del Imaging, and Nanticoke Hospital have implemented an image sharing service through DHIN. URL links are added to the radiology reports sent into the DHIN Community Health Record. These links interface with the source imaging system or an offline cache of recent images, giving providers the capability to view images from the DHIN CHR portal, and even compare with previous studies. The three currently participating data senders account for 11% of all imaging results sent into the Community Health Record, and span the three counties of the state.

DHIN Electronic Public Health Reporting

DHIN connects to the state's public health electronic lab reporting system for real-time delivery of reportable diseases. Through the emergency department (ED) admission transactions, DHIN receives the relevant lab report for the patient's visit and routes it to the patient's provider, as well as to the Delaware Electronic Reporting and Surveillance System (DERSS) in real-time standardized format. By state regulation, all Delaware hospitals must send this data through DHIN to Public Health, using the most current technology standards.

DHIN Electronic Syndromic Surveillance Reporting

DHIN connects to the state's public health bio-surveillance system for real-time delivery of emergency chief complaint data. Through the emergency department (ED) admission transactions, DHIN receives the relevant chief complaint for the patient's visit and routes it to the patient's provider, as well as to the Delaware Electronic Reporting and Surveillance System (DERSS) in real-time standardized format. By state regulation, all Delaware hospitals must send this data through DHIN to Public Health, using the most current technology standards.

DHIN Immunization Registry and Query

DHIN provides a web-service that enables both electronic reporting to and query of the state immunization registry, DelVax. Automating the submission of this data electronically through a web service interface improves reporting timeliness and accuracy and results in a more up-to-date record of each patient's immunization status. Currently, this service is used by 100% of Delaware hospitals, 77% of Delaware pharmacies, and 32% of ambulatory practices, with many more in various stages of testing or onboarding.

DHIN Newborn Screen Electronic Reporting

Newborn screening consists of early hearing detection and a set of lab tests for early detection of harmful metabolic and congenital conditions. DHIN has worked with Public Health and the state's hospitals and birthing centers to enable the electronic reporting of early hearing detection testing through DHIN to Public Health. DHIN is currently working with Public Health to automate combining the results of the hearing detection and metabolic screening into a composite newborn screening report that can be delivered by DHIN to the birth hospital and the provider who will be caring for the baby.

Consulting Services

DHIN has provided consulting services to the state of Hawaii in standing up their HIE, and has provided varying levels of consulting support to other states on specific topics.

Direct Secure Messaging – This service enables secure, encrypted point-to-point exchange of information between individual entities or organizations which have established a trust relationship, using the ONC-adopted standard for such communication. Many but not all providers receive this service directly from their EHR vendor, but DHIN offers the option for users to subscribe to this service through us if they do not already have access to it from other sources.

We have a few subscribers among organizations not yet using an EHR, to include paper-based practices and provider types not eligible for the CMS EHR Incentive Program (primarily behavioral health and long term and post-acute care organizations. Adoption of this service is low.

Specimen Location for Research – This service enables DHIN to connect researchers looking for biological specimens (blood, serum, tissue, etc.) meeting specified parameters with laboratories holding specimens meeting those parameters. With patient consent, once biologic specimens have been used for the intended clinical purpose, the residuals which remain and would otherwise be discarded can be made available to researchers under IRB-approved research protocols.

Analytics/Reporting Service

DHIN has recently launched an analytics and reporting service, used primarily by ACOs who seek to understand the activity of their patients outside their own network. Because DHIN receives data from all hospitals, labs, and nearly all imaging centers as well as a small but growing number of ambulatory practices and urgent call centers/walk-in clinics, DHIN is uniquely positioned to provide this service.

Fraud Detection

DHIN's "Health Check Alert" service allows subscribing patients receive a text message alert whenever new data is received by DHIN about them, or whenever a user accesses their information in the Community Health Record. Similar to the processes used by credit card companies for fraud alerts, the patient then sends a simple reply indicating whether they do or do not recognize the activity as legitimate. Additional benefits to the patient include the knowledge of who is accessing their health data, and awareness of when test results are available, both to the ordering provider and to the patient directly through a patient portal/PHR. Health plans are also target customers as receiving notifications from their patients about an incorrect transaction allows them to pursue any potential fraudulent activity before the claim is paid.

**DHIN Services Currently Under Development**:

Health Care Claims Database (HCCD)

The Delaware General Assembly passed legislation in 2016 authorizing DHIN to stand up a Health Claims Database. Reporting to this database will be required for Medicaid and state employee health plans, qualified health plans on the Marketplace, and federal sources such as Medicare. Other health plans may report data on a voluntary basis. Broad use cases contemplated include support for population health initiatives, provider risk sharing, and consumer shopping. DHIN has recently completed a successful proof of concept and began receiving data in May of 2018.

Medical Orders for End-of-Life Care

The Delaware General Assembly has enacted legislation to establish a common form and accompanying policies and procedures to incorporate patient end-of-life care preferences into a concise set of medical orders (DMOST) which must be honored across the state in all care settings. DHIN is authorized to establish a registry for these orders. We are currently working with the DMOST working group to develop and implement this registry.

**DHIN Functionality – Future Plans**

Mental Health/Behavioral Health Data Exchange

Exchange of mental health data requires more than the usual privacy and security tools. DHIN currently is able to support the granular patient consent that is necessary to restrict viewing of behavioral health data to specific individuals the patient has consented to have such access. Few behavioral health organizations in Delaware currently use electronic health records, but as this number grows, there will be value in including such data in the Community Health Record.

New data types and data sources

The social value of the Community Health Record as well as the value of the DHIN data repository is greatest if all the data are "in" and all the healthcare community is using it. The value can be augmented with the addition of:

Ambulatory data – DHIN expects to continue a focus on the goal of widespread CCD contributions from the ambulatory setting. Currently, approximately 13% of DE providers contribute such data.

Claims data – many elements of a claim are useful proxies for clinical information, such as procedure and diagnosis codes, as well as a complete listing of providers seen and medications filled. DHIN has a data use agreement with the dominant carrier in our market, but we have not yet implemented the data feeds for the use of incorporating this data for clinical use.

Medical device data – EKGs and other devices with output which is graphic or pictorial rather than primarily text or number based, as well as home glucometers and scales would provide very valuable additions to the Community Health Record and enhance care across the care continuum.

Data from the long term and post-acute care (LTPAC) organizations – These data sources are very important to support the analytics needs of ACOs and providers considering entering into risk-bearing contracts. A small but growing number of LTPAC organizations use electronic health records, but a solid business case to entice them to participate in the information exchange ecosystem has been elusive. DHIN will continue efforts to engage this important group.

Care Gaps

Based on accepted clinical guidelines and using all data from all sources contained in the DHIN repository, DHIN would provide notification of possible gaps in care to enable proactive case management and care coordination.

Risk Stratification

Identify high risk patients for special care coordination. This is a necessary activity under some of the newer delivery and payment models, such as Patient Centered Medical Home. The cost of providing this service could be reduced if a single tool and set of risk stratification algorithms is used across the state.

Clinical Quality Measure Reporting

Practices may be reporting under multiple programs, such as Meaningful Use, MIPS, and to one or more health plans. DHIN could be the clearing house such that the practice submits all measures once to DHIN, and DHIN reports out to the various end points. DHIN aspires to become a Qualified Clinical Data Registry for this purpose.

**Discontinued Services**

Common Provider Scorecard

Under one of the initiatives of the State Innovation Model (SIM) grant received by Delaware, the major carriers and health plans have agreed on a common set of clinical quality measures, utilization metrics and cost metrics and they report this data to DHIN quarterly. DHIN then publishes a Common Provider Scorecard which enables subscribing providers to see their performance on these measures across their entire practice and also stratified by payer and health plan.

### 2..5.6 Private Sector Efforts

Christiana Health Care System, headquartered in Wilmington, Delaware, is one of the country's largest health care providers, ranking 16th in the nation for hospital admissions. Christiana Care includes two hospitals, one of which is a major teaching hospital and Delaware's only Level 1 trauma center. It also includes a home health care service, preventive medicine, rehabilitation services, a network of PCPs and an extensive range of outpatient services.

The Nemours/A.I. DuPont Hospital for Children, also located in Wilmington, is a Level II Pediatric Trauma Center and the only children's hospital in the state. Nemours has a fully integrated EMR that enables all patient data to be captured, monitored, and used to continuously improve patient health. These electronic capabilities have eliminated prescription error rates, allowed tracking of Body Mass Index (BMI) and improved communication among clinicians, referring physicians and patient families. Nemours currently uses an Epic EHR both in their inpatient and ambulatory settings.

# 3 THE VISION OF HIT FUTURE

The State of Delaware has had a developing vision for the future of HIT since 1997 when legislation was enacted to establish the DHIN. In 2007 the DHIN became the first operational statewide HIE in the country. Over the years, the State has continued to augment and deploy DHIN across the state and continues to expand efforts for DHIN to support not only the state's providers but also other state agencies and programs in achieving automated exchange of health information to facilitate business operations. This plan shows the complementary vision between DMMA and other stake holders such as the DHIN. The DMMA's vision is focused on Stage 1, Stage 2 and Stage 3 MU. The plan also explains DMMA's medium and long term plans as one of the many state agencies to partner with the DHIN. DMMA believes the short- term plan adequately prepares the Division for the anticipated future MU requirements and can be augmented to meet final requirements. DMMA's two commercial MCOs have been receiving Event Notification alerts from hospital emergency rooms. An MCO roster file is used to match results delivery. Targeted clinical data alerts may be developed next. This will help the Division greatly improve health outcomes and reduce the cost of health care.

## 3..1 Participating Entities

Most of Delaware's HIT activity is being driven and coordinated under the HIE Cooperative Agreement as developed by the DHIN in collaboration with other state agencies. The DHIN has developed and maintains strong ties to the majority of health care entities in Delaware. The DHIN has a strong working relationship with DMMA, which is also represented on the DHIN Board of Directors. Additionally, the DHIN works with the DSAMH, DSCYF, DPH, and Department of Corrections (DOC). Delaware's collaborative environment brings together consumers, hospitals, health plans, physicians, and reference laboratories to focus on efficient and effective health care through HIE. As the convener of these activities, DHIN has a central role in Delaware's health care system, revolutionizing how patients receive health care in the State.

This section identifies the governance of entities and organizations that are involved in the state's HIT activities. Additionally, it shows the many initiatives to be considered for inclusion into the State's vision, as they contribute to the ongoing adoption of HIT in the State.

### 3..1.1 DHIN Governance

DHIN's 1997 enabling legislation (Delaware Code Title 16, Part XI, Chapter 99, Subchapter 9922) details that the Powers and Duties of this public-private partnership are to develop a community-based health information network to facilitate communication of patient clinical and financial information, designed to:

- Promote more efficient and effective communication among multiple health care providers, including, but not limited to, hospitals, physicians, payers, employers, pharmacies, laboratories and other health care entities
- Create efficiencies in health care by eliminating redundancy in data capture and storage and reducing administrative, billing, and data collection costs
- Create the ability to monitor community health status
- Provide reliable information to health care consumers and purchasers regarding the quality and cost effectiveness of health care, health plans and health care providers

DHIN holds the distinction of becoming the first statewide clinical HIE in the nation.

The Public-Private Board of Directors is comprised of diverse organizations representing the primary stakeholders of HIE. The Board consists of approximately 30 percent of directors representing the public sector and 70 percent of directors representing the private sector. They include representatives from the following constituency groups, organizations and agencies:

- Consumers
- Providers
- Payers
- Public: Delaware State government agencies, including Delaware Comptroller General, DTI, DMMA, Office of Management and Budget
- Employers
- Researchers

An Executive Director oversees the day-to-day operations of the project with support from staff, guidance from the DHIN Executive Committee, advisory committees, and ad-hoc workgroups that steer the project and ensure input and buy-in from all stakeholder groups. Stephen Groff, Director of DMMA, was appointed to the Board by the Secretary of DHSS.

The HIE Cooperative Agreement Workgroup works to advance the DHSS tasks outlined in the HIE Cooperative agreement. This workgroup includes DHSS members from: DDDS, DMS, DMMA, DPH, and DSAMH.

### 3..1.2 Regional Extension Center

QID is Delaware's QIO and REC. QID's contract with ONC ended March 31, 2014. Since the end of the ONC grant with QID, the REC has assisted with EHR Incentive Program attestations on a fee-based basis. QID administered the Doctor's Office Quality – Information Technology (DOQ-IT) program in Delaware and was extremely successful in helping Delaware providers implement EHR systems. QID is a strong and active proponent of DHIN, and collaborates with DHIN under contract, to support physician practices with interfacing their EHRs with the HIE. The Chief Operating Officer (COO) of QID is an active member of the committee that reviewed vendor responses to the technical request for proposal (RFP). Additionally, the COO took part in the vendor demonstrations and subsequent vendor selection. QID has enabled targeted Delaware hospitals and many physician practices to implement HIT, and in conjunction with DHIN, meet the MU standards.

QID has assisted 1,500 Delaware Medicaid/Medicare providers with direct, individualized, and onsite technical assistance in:

- Selecting a certified EHR product that offers best value for the providers' needs
- Achieving effective implementation of a certified EHR product
- Enhancing clinical and administrative workflows to optimally leverage an EHR system's potential to improve quality and value of care, including patient experience as well as outcome of care
- Observing and complying with applicable legal, regulatory, professional, and ethical requirements to protect the integrity, privacy, and security of patients' health information

### 3..1.3 Education

Delaware does not have an institute of higher medical education in the state. However, there is a long-standing relationship with two universities in nearby Philadelphia, Pennsylvania. The Delaware Institute of Medical Education and Research (DIMER) was created in 1969 by the Delaware General Assembly as a cost effective alternative to establishing a medical school in Delaware. DIMER provides enhanced opportunities for Delaware residents to obtain medical education by providing financial support to Thomas Jefferson University's Medical College and Philadelphia College of Osteopathic Medicine in exchange for reserved admission slots for qualified Delaware residents. Scholarships and tuition supplements are available for participating students. DIMER's relationship with the institutions has facilitated and enhanced collaboration on health-related initiatives in Delaware.

In March 2009, a new coalition of leading education, healthcare and medical research institutions,

the Delaware Health Sciences Alliance, was created. The partners include Thomas Jefferson University, University of Delaware, CCHS, and Nemours/A.I. DuPont Hospital, whose common priorities are world-class healthcare education; interdisciplinary “bench-to-bedside” research; and better healthcare quality and delivery. Their goal is to improve health and health services to all Delawareans through the nurturing of research and the development of advanced technology. Through the coalition, major research centers are being considered in the areas of cardiovascular disease, cancer, women's and children's health neuroscience and health policy. DHIN has had preliminary discussions with the Coalition to discuss the potential patient data available to DHIN. The DHIN will continue to play a role in the growth and development of the new and exciting opportunity in Delaware.

### 3..1.4 State Loan Repayment Program (SLRP)

The Delaware State Loan Repayment Program (SLRP) is designed to recruit dental, primary care, and mental health professionals to federally designated provider shortage areas (HPSA) in Delaware. The program is managed by Delaware Health Care Commission (DHCC) and collaborates with several public and private community organizations, such as hospitals, non-profits, and government facilities. Participating clinicians commits to providing health services in HPSA designated areas for two to four years. Eligible clinicians can receive an award ranging from a minimum of $30,000 to a maximum of $100,000 towards existing student loans with qualified loan providers. As of Dec. 31, 2016, the program has successfully awarded $4,856,177 to advanced level (99) practitioners and $610,632 to mid-level (29) practitioners in health professional shortage areas in Delaware. Additional information about SLRP is available at http://dhss.delaware.gov/dhcc/slrp.html.

### 3..1.5 State Universities

The University of Delaware is an active participant in statewide HIT projects. The University participates on the DHIN Board. Additionally, the Center for Applied Demography and Survey Research has been instrumental in conducting physician technology capacity studies for DPH. The Center has also participated in digital literacy initiatives for DTI.

### 3..1.6 DHSS

There are several groups under the DHSS umbrella that are active participants in activities related to HIT/HIE, and involved in developing and implementing elements of the vision. These groups are described below.

- **DMMA HIT Steering Committee** - This group will continue to meet either in-person, through webinars or conference calls throughout the life of the project and provide oversight and direction to the EHR incentive program, and DMMA integration with other HIT projects. The HIT Steering Committee is led by the Medicaid HIT Coordinator (program manager for EHR Incentive Payment Program). Periodically, the HIT Steering Committee members are apprised of the progress of the Medicaid HIT initiatives and the EHR Incentive Program through email summaries and reporting documents. The composition of the committee is as follows:
    - DMMA Director and/or designated Deputy Director
    - Chief Administrator of Information Systems
    - Chief of Administration, DMMA
    - Administrator, Division of Public Health
    - Administrator, Program Integrity
    - Administrator, Planning, Policy and Quality
    - Administrator, Managed Care Operations
    - DXC Provider Incentive Payment Team members
    - Medicaid HIT Analyst
- **MAPIR Collaborative –** Delaware participates in a collaborative with 14 other states where DXC serves as the Medicaid FA. MAPIR performs the functions of a state level repository and interface for verifying provider eligibility, receiving attestations, and making payments to manage the participating states' EHR incentive programs. The following states have joined the collaborative:
    - Arkansas
    - Colorado
    - Connecticut
    - Delaware
    - Florida

- Georgia
- Indiana
- Kansas
- Massachusetts
- Oregon
- Pennsylvania
- Rhode Island
- Wisconsin
- Vermont

- **DPH:** DPH includes a wide range of programs and services to improve the health of the people who live and work in Delaware. **Mental Health/Substance Abuse:** DSAMH is interested in the ability to improve communications between physicians in various settings and seeks to utilize HIT. DSAMH's goals include standardized measures, efficient communication, and strategies for improving outcomes and performance while maintaining confidentiality and medical ethics.

### 3..1.7 FQHC/RHCs

The State's two FQHCs are active participants in the DHIN network. The FQHCs provide significant amounts of care to low-income, medically underserved populations; Westside Family Healthcare located in Wilmington, greater New Castle County, and Dover and La Red Health Center located in Georgetown and Seaford serve a majority of minority individuals with limited English proficiency.

### 3..1.8 Veterans Medical Centers

Delaware has a Veteran's Medical Center located in Wilmington. The local Veteran's facility is not currently a partner in state HIT efforts. However, through ongoing coordination with the eHealth Exchange, or another broader national level exchange, the EHRs within the Veterans Administration (VA) will be accessible through the DHIN in the future. In July 2018 DHIN is discussing with the local Veteran's Administration leadership how we may enter into an API-mediated data exchange. DHIN has the platform and the API specifications for this type of connection with the VA. The VA has made a commitment to support API-based exchange in principle so we will continue to discuss and plan. If we can achieve this in Delaware, would get data not just on DE veterans from the VA hospital in Wilmington, but from the master VA data repository. The data would be accessible to Delaware Providers through the DHIN Community Health Record. The timeline for this development would include negotiating a legal agreement between the VA and the DHIN. A template of the DHIN's data sender agreements has been shared and both organizations are aware that they must work through difference consent models for patients. DHIN uses an opt-out model and the VA uses an opt-in model. There are no concrete plans at this time to develop the API connections, however, these are the steps that must first be taken to realize a VA/DHIN data connection.

### 3..1.9 IHS/Tribal Government

IHS is not involved in state HIT efforts, as Delaware does not have IHS/Tribal Governments.

### 3..1.10 Broadband Grantee

The DTI is the State broadband grant awardee to conduct statewide data collection and mapping on broadband. Governor Carney supports wireless broadband access and views broadband as a key player in support of economic growth and development, education, and public safety initiatives. In April 2018, Governor Carney developed an Action Plan for Delaware and the top two priorities are the identification of broadband deserts and the expansion of broadband internet access in under-served areas of the State.

### 3..1.11 Health Plans

By statute, the DHIN Board of Directors includes representation from up to three health plans. Currently, the position is filled by Highmark Blue Cross Blue Shield Delaware. In addition, health plans are represented on the DHIN Executive Committee, and Governance and Finance Workgroups.

Some health plans in Delaware supporting state health programs are

- Amerihealth Caritas – Provides Managed Care Services for Medicaid.
- Health Options – A part of Highmark Blue Cross Blue Shield Delaware. Provides Managed Care services for Medicaid.

### 3..1.12 Professional Associations

State professional associations are collaborative partners on various state and federal initiatives and attend DMMA's quarterly Provider Association meetings. Provider Association meetings are held quarterly to discuss current state and federal initiatives, and address any provider issues or concerns. Several of the associations have been members of the DHIN governance structure.

Key professional health association partners in Delaware are described below:

- Delaware Academy of Family Physicians (DAFP) - The philanthropic arm of the DAFP, and a networking member of the American Academy of Family Physicians Foundation. Founded in 1991, the DAFP/Research and Education Foundation (REF) Foundation is dedicated to advancing primary health care throughout Delaware by supporting Family Medicine.
- Delaware Chapter of the American Academy of Pediatrics – Promotes health care services that will provide optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults.

- Delaware Health Care Association (DHCA) - A statewide trade and membership services organization that exists to represent and serve hospitals, health systems, and related health care organizations in their role of providing a continuum of appropriate, cost-effective, quality care to improve the health of the people of Delaware. The primary role of the Association is to serve as a leader in the promotion of effective change in health services through collaboration and consensus building on health care issues at the State and Federal levels.
- Delaware Health Care Facilities Association (DHCFA) - DHCFA is a nonprofit organization of nearly 55 licensed health care facilities representing providers of Assisted Living Services, Intermediate and Skilled Nursing Services, Rest-Residential Services as well as Sub Acute or Short-Term Rehabilitative Services
- Delaware Medical Group Management Association (DMGMA) - A State chapter of the national Medical Group Management Association (MGMA) and the only organization in Delaware dedicated to the professional development of practice managers
- Delaware State Dental Association - The Delaware State Dental Society support dentists through education and advocacy and works for the advancement of quality oral health care for the public
- MSD – The Society furthers the ideals of the medical profession through advocacy, representation, education, and the advancement of public health and well-being
- National Association of Chain Drug Stores (NACDS) - NACDS represents traditional drug stores, supermarkets, and mass merchants with pharmacies - from regional chains with four stores to national companies.

### 3..1.13 Other Groups

DHSS/DMMA also collaborates and coordinates with other providers and provider groups in Delaware including the following:

- BayHealth - Central and Southern Delaware's largest healthcare system, BayHealth is comprised of Kent General and Milford Memorial Hospitals, Middletown Medical Center and numerous satellite facilities. BayHealth is a technologically advanced not-for-profit healthcare system employing over 2,900 with a medical staff of 458 physicians. BayHealth currently serves on the DHIN Board of Directors.
- Center for Pediatric and Adolescent Medicine - Dedicated to the development of the whole child, this practice provides quality, compassionate, and culturally sensitive care in a child centered and family friendly environment
- CCHS - Headquartered in Wilmington, CCHS is one of the country's largest health care providers, ranking 16th in the nation for hospital admissions. Christiana Care is a major teaching hospital with 2 campuses and more than 24 Medical-Dental residents and fellows. CCHS currently serves on the DHIN Board of Directors.

## 3..2 Vision for HIT Environment

Delaware envisions an integrated automated health exchange system that will support statewide health activities and operations, and has engaged in a variety of activities to further that vision. DMMA has invested in the State's vision through assisting in the development of the HIE cooperative agreement, encouraging HIT adoption and automation of administrative healthcare activities. The Division has structured all HIT activity to support further development, utilization, and promotion of the DHIN and other state HIT initiatives that encourage collaboration and participation.

The statewide vision is to develop a network to exchange real-time clinical information among all health care providers. The healthcare providers include office practices, community clinics, hospitals, laboratories and diagnostic facilities across the State. The goal is to improve patient outcomes and patient-provider relationships, reduce service duplication, and decrease health care spending. DMMA works with the DHIN to provide the Medicaid managed care organizations (MCO) with hospital event notification. This started as a pilot with two hospitals and now includes all hospitals in the state. Admission, Discharge, and Transfer (ADT) information are provided to the two Medicaid MCOs on a daily basis. DMMA continues to work with the DHIN on several MCO related DHIN projects including the Provider Scorecards in support of Value Based Payments, exchange of clinical data for high risk members to MCOs from DHIN for care coordination, and transmission of claims data from Medicaid MCO members to the DHIN to be matched with clinical information in the community health record.

Five primary objectives serve as the basis for interoperability and HIT among all health care providers in the State of Delaware:

1. To improve the care received by patients served by Delaware's health care system and to reduce medical errors associated with the often inaccurate and incomplete information available to providers of medical care.
2. To reduce the time required and financial burdens of exchanging health information among health care providers and payers (necessary for patient care), by addressing the currently siloed model, distribution methods lacking integration and dramatically increasing use of electronic means.
3. To improve communication among healthcare providers and their patients to provide the right care at the right time based on the best available information.
4. To reduce the number of duplicative tests to afford specialists a more comprehensive view of the patient upon referral from his/her PCP and to expedite the reporting of consultant opinions and tests/treatments between specialists and the referring physicians.
5. To improve the efficiency and value of EHRs in the physician office and to assist those physicians without an EHR to better organize and retrieve test results.

The DHIN provides the technical infrastructure to allow for data exchange with health care facilities, provider EHRs, existing, or emerging HIEs/Regional Health Information Organizations (RHIOs) in other states, and eventually the eHealth Exchange. Other supporting activities,

including the Delaware EHR Incentive Program, will provide support to accelerate provider automation and connectivity to the network.

Medicaid business functions are part of the state HIE strategic plan. DHIN will eventually support a variety of administrative transactions that assist the Medicaid business processes. Planned features include:

- Eligibility verification – both batch and real-time transactions
- Benefit Inquiry – verification of coverage, limitations, out-of-pocket maximums, and requirements
- Claims Submission – single or batch processes

DHIN anticipates implementing the following functionalities:

- DHIN Electronic Clinical Laboratory Ordering and Results Delivery
    - Both initiatives could not be completed due to changing priorities for the hospital lab and the inability to contract with one of the EHR vendors. The DHIN has, therefore, not been able to initiate scheduled orders because the electronic orders initiative could not be implemented.
- DHIN Quality Reporting Capabilities
    - DHIN leverages the foundational data stores by providing quality of care reports and analytic tools. Using an Internet-based tool, users can generate patient lists with key identifiers, and initiate follow-up care. DHIN began a pilot project with Active Health to support the delivery of Care Considerations to DHIN providers which will be the first step toward clinical decision support activities. Due to DHIN's vast amount of patient records, clinical results and uniquely identified physicians provide an essential foundation for a strong quality reporting environment.

**Measuring MU Compliance**

DHIN can help Medicaid document the compliance of health care professionals and ACHs with the MU criteria. DHIN has visibility into:

- Physicians using a certified EMR
- Electronic exchange of information
- e-Prescribing and medication history
- Computerized Provider Order Entry (CPOE) adoption

**Medicaid Vision and Mission**

The Delaware Medicaid Vision Statement plays a critical role in defining the future direction of the Medicaid Enterprise. Its derivation is dependent upon intimate knowledge over a broad spectrum of business process areas, their interdependencies, and their relative strengths and weaknesses to one another both within and outside of the Enterprise. The Vision statement,

strategies, and specific future goals are formulated to describe anticipated outcomes. The Delaware Medicaid Mission and Vision Statements are listed in Table 8 below.

**Table 8 DMMA Guiding Principles and Objectives**

| Delaware Medicaid Guiding Principles | |
|---|---|
| Mission Statement | "The mission of the DMMA is to improve health outcomes by ensuring that the highest quality medical services are provided to the vulnerable populations of Delaware in the most cost effective manner." |
| Vision | "Through innovation, enhance medical coverage to meet the diverse needs of Delawareans." |

DMMA has developed a selective list of prioritized projects, and has provided implementation guidance to target improvements for the existing Medicaid Enterprise, based on assumptions, constraints and current DMMA visibility. All targeted improvements were a result of the MITA SS-A effort and were consistent with the MITA To Be strategy.

The projects were prioritized into six priority levels. Contained within each level is a matrix of supporting themes. The themes are aimed at promoting a number of objectives including: an expanded Service Oriented Architecture (SOA), cost efficiency and effectiveness, and increasing business process maturity levels across the Medicaid Enterprise. Supporting themes included but were not limited to:

- Standardization of data across the Medicaid Enterprise
- Accessibility to electronic clinical data to improve patient outcomes
- Interoperability to facilitate external stakeholder interaction with electronic interfaces
- Integration and centralization of enterprise processes

The matrix below provides a sampling of the highest priority projects matched to those themes recurring most often.

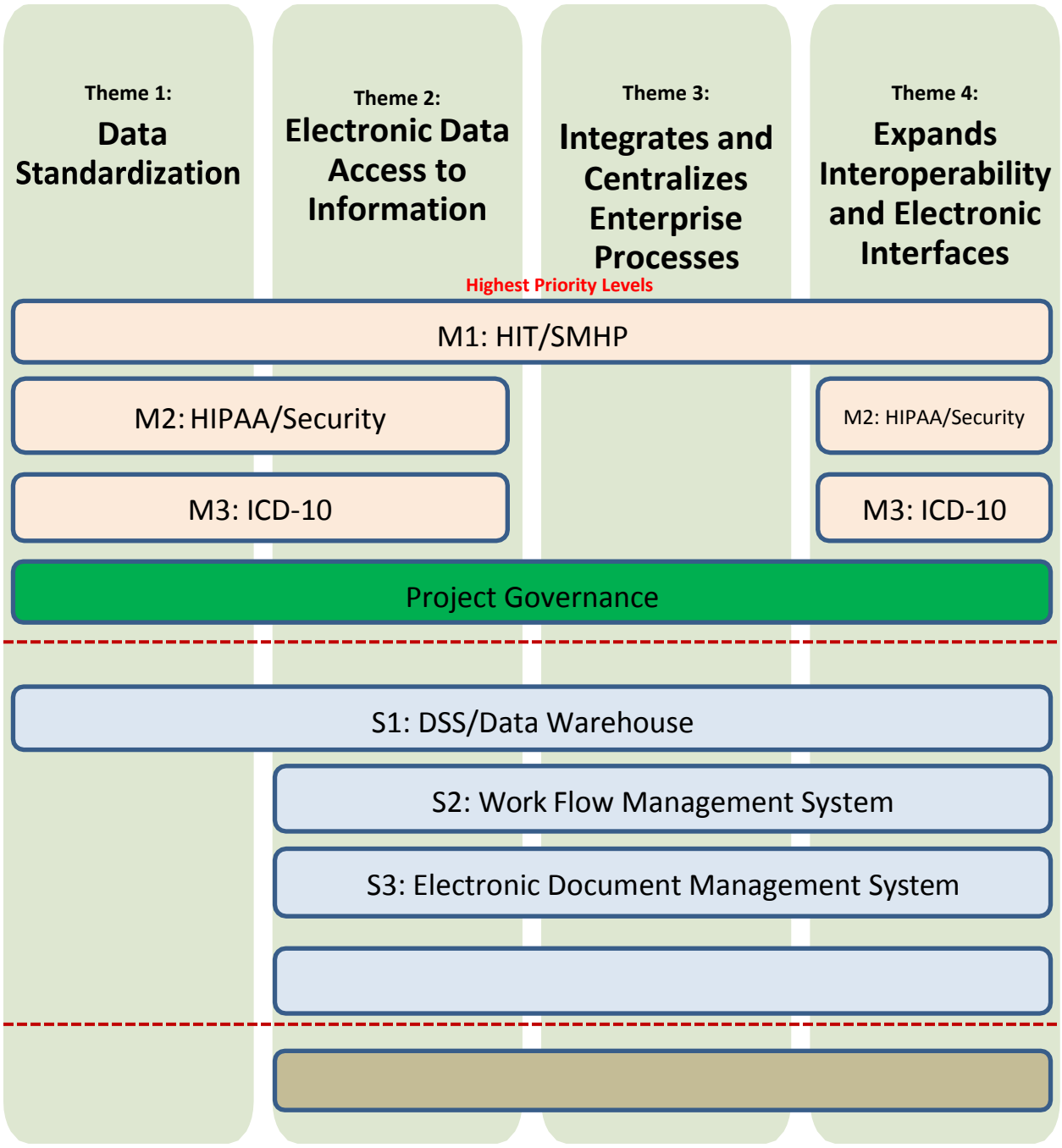



**Figure 2 Highest Priority Projects**

It was concluded that the greatest and most immediate benefits would come from compliance with federal project initiatives and mandates. Enhancements would address a number of highly concentrated and recurring themes starting with HIT/SMHP.

DMMA will align the Delaware EHR Incentive Program and Medicaid HIT goals with the statewide HIT/HIE goals to adopt national standards as available and promote participation in statewide HIE.

The MAPIR system allows providers to electronically enroll into and attest for the Delaware EHR Incentive Program; the application accommodates registration, enrollment, attestation, verification, and payment processes related to the Program. A direct result of the Incentive Program was the synergies involved in requiring attesting providers to comply with DMMA Electronic Funds Transfer (EFT) capability and Provider enrollment requirements. The system supports automated bi-directional connectivity to the Medicare and Medicaid EHR Incentive Program R&A System and MMIS provider, recipient, and claim data. Providers are able to attest to Stage 1 MU through the MAPIR system. MAPIR is regularly updated to comply with CMS changes to the requirements for the EHR incentive program. Providers are able to attest to Stage 2 MU through MAPIR and will be able to attest to Stage 3 in 2018. DHIN will develop methods to access data from DMMA through the DW/DSS. As part of the HIE cooperative agreement plan this project will lay the groundwork for collecting MU and quality measures in an automated manner for future MU stages. Additionally, this mechanism will provide a means to collect MU data for reporting from MAPIR and eventually the R&A System/CMS. As connectivity grows, the Division can utilize this data for development of policy and assessment of providers and programs. The DW/DSS will also create a gateway to send data to DHIN and allow for improved coordination of services for Delaware's Medicaid clients. This DW/DSS may also provide a means for Medicaid to deliver the necessary data to DHIN to allow the HIE to identify clients and providers associated with Medicaid and other medical assistance programs so that claims and eligibility inquiries can be appropriately routed. The DHIN is capable of sending targeted clinical messages to the Medicaid MCOs and/or to DMMA based on a population identified through these data exchanges.

Through developments in data exchange HIEs will enhance care coordination opportunities, eliminate duplication of services, and foster identification of appropriate levels of care. DMMA will be able to more effectively identify serious quality of care issues, gaps in care, member compliance issues, and member behavior trends in areas such as emergency room (ER) utilization. DMMA also envisions that the HIE can be used to simplify internal operations, e.g., accessing medical record information for Healthcare Effectiveness Data and Information Set (HEDIS) measures, claims processing medical record review, and providing additional information for complex case management.

Delaware is engaged in an effort to transform our health system, with the goal of improving the health of Delawareans, improving the patient experience of care, and reducing health care costs – the Triple Aim. This document is Delaware's State Health Care Innovation plan, which has been developed with support from the State Innovation Models initiative. This is designed to be a plan for all Delawareans – not the government or any individual stakeholder. It represents the coming together of the health care community, including consumers, clinicians, community health centers, health systems, payers, and the State to articulate a plan for how we can meet the challenges we face together. It is a State Health Care Innovation Plan for individuals and the health care community in Delaware and we are committed to implementing it. In order to implement it, we have examined the way care is delivered and received, the resources we have and those we need to build, and the way we work together today.

As outlined in Delaware's State Health Care Innovation Plan, this State aspires to lead the nation in innovation and impact on each dimension of the Triple Aim: improving the health of Delawareans, improving health care quality and patient experience, and reducing health care costs. In order to achieve this vision, Delaware intends to move towards a more patient- centered, value oriented, technology-driven, and simpler model of care that builds from Delaware's many strengths and ongoing innovation. In particular, Delaware aims to achieve the following specific goals by 2019:

- Delaware will be one of the five healthiest states in the nation; and

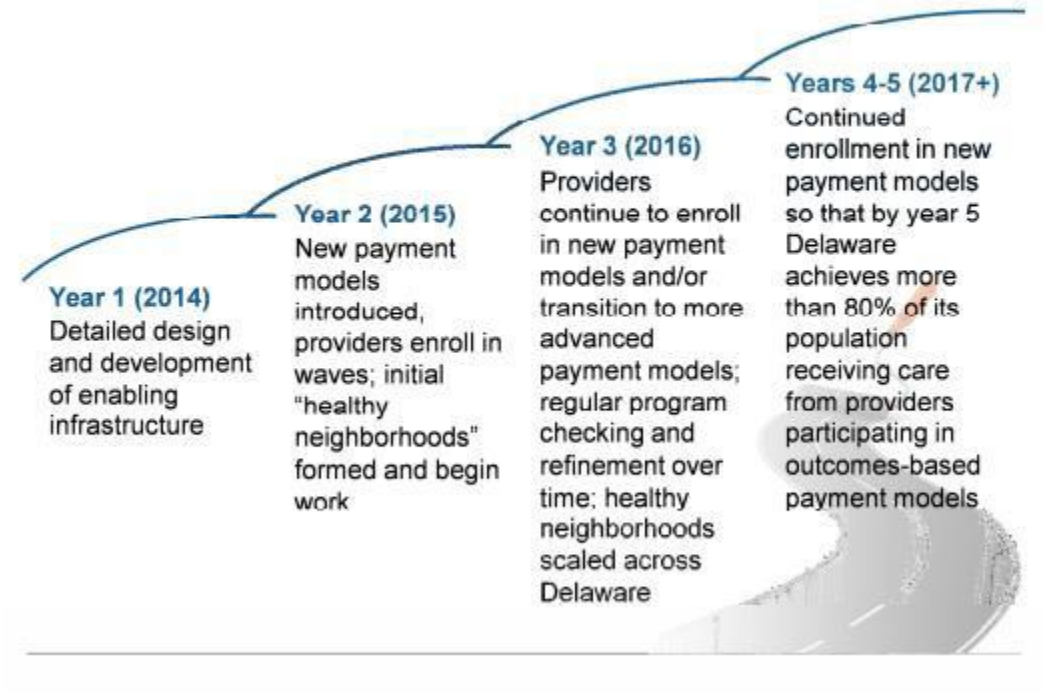
- Delaware will be in the top ten percent of states in health care quality and patient experience; and

- Delaware will reduce health care costs by 6 percent. Success requires progress on each goal – this will create real value for the health system and, more importantly, improve health for all Delawareans.

Delaware's plan is distinctive in many respects. The flexible and inclusive framework creates an environment supportive of delivering coordinated, team based care across all of Delaware's providers. The plan builds from strengths, leveraging, for example, Delaware's leading health information technology infrastructure. The breadth and depth of stakeholder engagement in co-designing the plan ensures that it reflects the real needs and challenges faced by Delaware's consumers, providers, payers, and employers. The State has been committed to this plan, serving as an active participant in its role as a convener, provider, and purchaser of care. Overall, Delaware's plan offers a scalable, replicable model for national health care transformation. This approach puts Delaware on a sustainable path to deliver on its goals for achieving the Triple Aim.

Delaware has been unique in its comprehensive approach to integrate across federal programs, including funding for health information technology infrastructure, Medicaid expansion, implementation of the Health Insurance Marketplace under the Affordable Care Act and this State Health Care Innovation Plan. The emerging approach to health system transformation will position Delaware as a national leader in health innovation and impact. The goal is for providers, payers, and the State to take steps toward implementation beginning in 2014. Over the next several years, Delaware envisions the following sequence of implementation:

HIGH-LEVEL IMPLEMENTATION ROADMAP




This year's work plan is centered on Healthy Neighborhoods, payment reform, behavioral health integration, and others –all supported by Health IT—and continue our efforts to transform health and health care for all Delawareans.

- Payment reform and related activities will be a major focus of our work this year. The Health Care Commission (HCC) will continue to support the Department of Health and Social Services in their efforts to construct and launch a health care benchmark. New models for payment will be developed in collaboration with Delaware payers, providers, and consumers. The HCC and its vendors will also continue to forward transparency and quality efforts through payment reforms on many fronts—linking with DHIN and the practice transformation efforts under SIM.
- Behavioral health integration will be the backbone of our practice transformation work. Founded on the plan developed in AY3, HCC will work with practices across the state to improve their capacity to address behavioral health needs alongside primary care. The HCC will also continue to support other practice transformation activities, and seek ways to support provider engagement in Delaware's Health Information Network (DHIN).

- Our Healthy Neighborhoods initiative was launched in the fall, and will propel population health efforts through the three county-based HN councils. In this year, the HCC will conduct a mini-grant program that allows these local councils to implement critical, evidence-based programs to improve population health. The HCC will also support population health through several other consumer-based efforts, including the state employees' programs and elsewhere.
- Health IT and health information exchange and transparency underpin the success and sustainability of all of these efforts. Without data, payment reforms can be lop-sided, practice transformation can be stymied, and local communities cannot target high-need issues and populations. Therefore, the HCC will continue to work with DHIN and invest in our HIT efforts—in concert with our other initiatives.

# 4 DMMA HIT STEERING COMMITTEE FOR THE MEDICAID EHR INCENTIVE PAYMENT PROGRAM

This section is a high-level description of the current Delaware EHR Incentive program including a description of its organization, operational process, and decision-making authority.

## 4..1 Program Organization

This section describes the Delaware EHR Incentive Program organizational structure, how the program relates to other Delaware programs, and the program's reporting structure.

### 4..1.1 Medicaid EHR Organizational Structure

- Medicaid Health Information Technology (HIT) Coordinator.
- The support team:
    - Medicaid HIT Analyst III
    - DXC Provider Incentive Payment (PIP) team
        - Staff and business analysts
        - DMES System programmers to support MAPIR and the EHR Incentive Program operations
- HIT Steering Committee
    - DMMA Director
    - DPH Administrator
    - DMMA Chief of Administration
    - DMMA Chief Administrator, Information Systems Unit
    - DMMA Chief Administrator, Program Integrity
    - DMMA Chief Administrator, Managed Care Operations
    - DMMA Chief Administrator, Planning, Policy and Quality
    - Medicaid HIT Coordinator
    - Medicaid HIT Analyst
    - DXC PIP Team

### 4..1.2 Key Stakeholders

Stakeholders in the Delaware EHR Incentive Program are those individuals and organizations who will participate in or are affected by the initiative. Key stakeholders have been identified as but are not limited to:

- DHIN
- Medicaid Providers serving Delaware residents
- Provider professional organizations
- Members/consumers
- REC
- MCOs
- CMS

Delaware organizations with a stakeholder relationship to the Delaware EHR Incentive Program include the following:

**Table 9 Organizations with Stakeholder Relationships**

| **Provider Type** | **Organization/** Technical Advisory Committee **(TAC)** | **Description** |
|---|---|---|
| Hospitals and Health Systems | DHCA | DHCA assists Delaware hospitals in working on issues concerning health care and the hospital industry. |
| | CCHS | CCHS, headquartered in Wilmington, Delaware, is one of the country's largest health care providers and is a major teaching hospital with two campuses. |
| | BayHealth | BayHealth is Central and Southern Delaware's largest health care system and is comprised of:<br>Kent General Hospital<br>Milford Memorial Hospital<br>Numerous satellite facilities |
| | DAFP | This organization advances health care throughout Delaware by supporting the specialty of Family Medicine. |
| | DMGMA | DMGMA is a state chapter of the national MGMA and is dedicated to the professional development of practice managers. |

| **Provider Type** | **Organization/** Technical Advisory Committee **(TAC)** | **Description** |
|---|---|---|
| | MSD | The MSD champions HIT and fosters education and communication; negotiates preferred pricing for EMR systems for MSD members. |
| | Center for Pediatric and Adolescent Medicine | This organization serves children across Central Delaware at two locations in a child centered and family friendly environment. |
| | Delaware Chapter of the American Academy of Pediatrics | This group helps its members and the community to promote health and wellbeing of infants, children, adolescents and young adults. |
| Multi-Type/ Influential | DHCFA | DHCFA consists of 55 health care facilities; both individual and multi-facility operations. |
| Dental | Delaware State Dental Association | Has over 300 members and its purpose is the advancement of quality oral health care for the public. |
| Health Plans | | Health Plans include:<br>Amerihealth Caritas (Medicaid MCO)<br>Highmark Blue Cross Blue Shield Delaware<br>Health Options (Highmark BCBS Delaware) (Medicaid MCO) |
| Health Departments | DPH | DPH includes a wide range of programs and services all aimed toward protecting and improving the health of Delaware's citizens. |
| Other | NACDS | NACDS represents drug stores, supermarkets, and mass merchants with pharmacies. |

### 4..1.3 Stakeholder Coordination

The Division has worked to develop collaborative approaches and long term support structures to promote and facilitate the incentive program. Collaborative approaches include:

- Participation in CMS sponsored events for providers
  - CMS HITECH Regional Meetings
  - CMS Community of Practice (CoP) webinars and Teleconference calls
  - Medicaid Enterprise Services annual Conference (MESC)
- DXC Multistate Collaborative to develop MAPIR
  - Bi-weekly Steering Committee meetings
  - Monthly Technical user group collaboration
  - Ad-hoc meetings
  - Monthly DHIN meetings

- Stakeholder Education – Stakeholders are invited to educational meetings through DMAP email alerts and Medical Society of Delaware "blast fax" notifications. Through Quarterly Provider Association Meetings hosted via on-line webinar and in person by DXC, the provider community and other stakeholders will have access to the details about the following:
  - Program Eligibility
  - Program Time line
  - A/I/U and MU of EHR technology
  - Program Registration and Application process guidance
  - Supporting organization contact information
  - Program Audit needs
- Support – Maintenance of communications are essential to ongoing relationships with stakeholders.
  - Periodic provider notification of timelines, requirements, and contact information
  - Periodic review of MAPIR Splash screens
  - Website information maintenance

- MAPIR documentation maintenance
- Call center procedure maintenance
- Medicaid EHR mailbox monitoring
- Ongoing meetings to collaborate with the REC and DHIN
- FAQs maintenance
- Appeal process communications

The goals of Stakeholder Coordination are to:

- Educate stakeholders on the benefits of the Delaware EHR Incentive Program and value of HIE to all health care stakeholders in Delaware, including providers, members/consumers, and payers
- Educate stakeholders on their role in making the Delaware EHR Incentive Program successful
- Mobilize key State stakeholders in the Delaware EHR Incentive Program and other organizations (e.g., provider organizations)
- Build commitment to the Delaware EHR Incentive Program across all stakeholders
- Effectively coordinate communications with all stakeholder organizations to develop broad awareness and understanding and minimize inaccurate or conflicting messages and information

Progress in achieving these goals is evaluated periodically over the course of the Delaware EHR Incentive Program implementation, and modification is/will be initiated as the need is identified.

## 4..2 Communication Vehicles

DMMA has several communication vehicles that are utilized to ensure providers receive the information needed and provide multiple channels for providers to contact the Division for assistance. The following methods are used:

- Training Events – DMMA will provide training events to explain the program to the provider community; utilize presentations and outreach material for handouts. One key event is the Division's quarterly Provider Association meeting.
- Meetings with medical professionals and organizations – the Division will meet with provider organizations to explain the program; utilize presentations and outreach material for handouts. One example was a recent HIT meeting with Nemours to discuss the role of the REC and the impact of the EHR Incentive program on the organization.
- Email Notification – The DMAP email notification will be used to disseminate information to stakeholders. Additionally, the listserv of partners in this initiative will be utilized to expand the reach of communications to target specific provider communities.

- Web site – Program information will be updated on the DMMA web site as well as to the DMAP web site. The DMMA website includes DMMA plans for the project, a FAQ section, and a link to the Delawarepipteam@dxc.com mail box.
- Call center – The DXC Provider Relations call center will provide application and program support by answering questions and providing guidance to providers throughout the program process.
- Automated systems – MAPIR contains splash screens to inform and guide the provider during application, and provide contact information for assistance.
- Appeal process – Providers are able to appeal decisions and explain their needs to the Division by entering an appeal directly into the MAPIR system. The PIP Team reviews and escalates the appeal as necessary while keeping the provider informed.
- Automated emails – As the provider moves through the MAPIR application process, the system generates email messages to inform the provider of the current status and the next steps of the application process.
- Media release - Informs the general public and the provider community of the success of the program and the first release of incentives.
- Telephone and email – Mechanisms for notification of stakeholder groups to inform them of key program events.

In February 2017 we submitted a separate SMHP addendum for Delaware outlining the changes we anticipate in implementing the Stage 3 portion of the 2015-2017 Modifications rule (so that eligible professionals have the option to attest to Stage 3 in 2017), the recently released OPPS rule, and any potential changes associated with the Quality Payment Program (QPP) [MACRA/MIPS]. We developed a communication plan to notify stakeholders of changes to the SMHP. The communication plan for the EHR Provider Incentive Payment Program is as follows:

## CMS Program Year 2017 EHR Incentive Payment Program Requirements Communication Plan

| Target Date | Stakeholder | Channel | Status |
|---|---|---|---|
| 1/27/2017 | Executive Leadership | Email, Verbal | Completed |
| 1/27/2017 | Executive Leadership Team | Virtual Leadership meeting | Completed |
| 5/9/2017 | Delaware State Dental Association | Email, Verbal | Scheduled |
| 5/9/2017 | DE Hospital Association | Email, Verbal | Scheduled |
| 4/29/2017 | DE EHR Incentive Program Participants | Email (via program distribution list) | Scheduled |
| 5/9/2017 | DE Medical Society | Email (via Association distribution list) | Scheduled |
| 4/29/2017 | Internal Staff & Vendors | EHR Operations Team Meeting | On-Going |
| 5/9/2017 | Provider Association Forum Meeting | Verbal with Power Point Presentations | Quarterly |
| 5/9/2017 | Medicaid MCO | Verbal | Scheduled |
| 01/27/2017 | Hit Steering Committee | Email, Verbal | Monthly Ad Hoc |
| TBD | Provider Education Webinar | Virtual Room | Not Scheduled |
| 2/18/2017 | Executive DMMA Leadership, DPH, MAPIR, HP Operations Team, State HIT Coordinator | E-Mail | Monthly Ad Hoc |
| 2/2/2017 | Executive Leadership - Delaware Health Information Network | Monthly meeting - verbal, email | On-Going |
| 1/6/2017 | All Stakeholders, Eligible Providers & Eligible Hospital | MAPIR Website - DMES | Completed |

The following is a Communication Plan updated for Program Year 2018:

**CMS Program Year 2018 EHR Incentive Payment Program Requirements Communication Plan**

| Target Date | Stakeholder | Channel | Status |
|---|---|---|---|
| Weekly | Executive Leadership Team | Leadership Team Meeting | Scheduled |
| 12/2018 | Delaware State Dental Association | Email, Verbal | Scheduled |
| 12/2018 | DE Hospital Association | Email, Verbal | Scheduled |
| 12/2018 | DE EHR Incentive Program Participants | Email (via program distribution list) | Scheduled |
| 12/2018 | DE Medical Society | Email (via Association distribution list) | Scheduled |
| Bi-weekly | Internal Staff & Vendors | EHR Operations Team Meeting | On-Going |
| Quarterly | Provider Association Forum Meeting | Verbal with Power Point Presentations | Quarterly |
| Monthly | Medicaid MCO Operations Meetings | Verbal | Scheduled |
| 12/14/2018 | Provider Education Webinar on PY 2018 | Virtual Room | Scheduled |
| Ad Hoc | Executive DMMA Leadership, DPH, MAPIR, DXC Operations Team, State HIT Coordinator | E-Mail | Ad Hoc |
| Bi-Monthly | Executive Leadership - Delaware Health Information Network (DHIN) | Bi - Monthly meeting - verbal, email | On-Going |
| Updated as needed | All Stakeholders, Eligible Providers & Eligible Hospital | MAPIR Website - DMES | Scheduled |

## 4..3 Privacy Regulatory Changes

At this time, DMMA does not believe that any changes are needed to state privacy laws or regulations for Delaware Medicaid and Medicaid providers to share and exchange health information for the Delaware EHR Incentive program and with entities outside of Medicaid.

The DHIN effort has already done extensive work to research, revise, and develop privacy policies and practices to protect patient information that is transmitted via the network. As set forth in the DHIN Statute, DHIN shall by rule or regulation ensure that patient specific health information be disclosed only in accordance with the patient's consent or best interest to those having a need to know. The health information and data of the DHIN is not subject to the Freedom of Information Act (FOIA), Chapter 100 of Title 29, nor to subpoena by any court. Such information may only be disclosed by consent of the patient or in accordance with the DHCC's rules, regulations, or orders.

Additionally, DHIN has implemented policies, procedures and/or protocols for privacy and security, provider relations and user management, and system monitoring. DHIN's privacy policy and procedures incorporate the privacy and security provisions of the ARRA, HIPAA Privacy Rule, HIPAA Security Rule, Confidentiality of Alcohol and Drug Abuse Patient Records Regulations, and adheres to all of the privacy principles articulated in the United States (US) Department of Health and Human Services (HHS) Privacy and Security Framework.

### 4..4 Other Regulatory Changes

No other regulatory changes are required at this time to implement the EHR Incentive Program in Delaware.

## 4..5 Provider Contract Changes

No provider contract changes have been identified to implement the EHR Incentive Program in Delaware.

### 4..6 HIT/HIE Activities Crossing State Boundaries

Delaware belongs to a multi-state collaborative led by the Commonwealth of Pennsylvania's Office of Medical Assistance Programs (OMAP) in association with DXC. The collaborative comprises of 14 states that have DXC as their FA and use the Medical Assistance Provider Incentive Repository (MAPIR), which is a web-based tool that supports the administration of the federal EHR Incentive Payment Program for providers and hospitals who serve Medicaid patients. The states in the collaborative have developed a system and operational steering committee that collaborates on processes necessary to operate the program and assist each state in meeting their unique needs.

Delaware works to establish contacts in surrounding states (Maryland, New Jersey, and Pennsylvania) to assist in establishing patient volume for providers that provide services across state borders and have Medicaid encounters in each state. DHIN currently exchanges ADTs with Maryland, DC, West VA, southern New Jersey, and 6 hospitals in Southeast PA. Exchange at this time is geography-based, meaning the HIE of the state where the patient lives gets a copy of the ADT if the patient is seen in the other states with which we exchange data. The DHIN reports that approximately 5% of all notifications received from the out-of-state hospitals and ED's. We began to gather MCO encounter data from DMES and query out-of-state claims to Medicaid beneficiaries from our data warehouse. However, the data was not clean enough to be analyzed by the due date of this annual SMHP and we will assign more resources to this analysis and report our conclusions next year.

### 4..7 MAPIR Overview

Delaware joined the MAPIR Multistate Collaborative described in Section 3 to implement the MAPIR module developed by DXC in Pennsylvania. Advantages of participation in a shared application are lower costs and simplified testing. MAPIR has received general R&A System testing approval as well as approval for all updates to MAPIR from CMS. States in the

collaborative are responsible for customizing and integrating MAPIR with their own systems and testing their individual connectivity with the R&A System.

MAPIR supports workflows associated with confirming eligibility for professional providers and hospitals, attestation requirements, suspense processing, data exchanges with the R&A, appeals tracking, issuance of incentive payments, and meaningful use data storage. MAPIR is designed to interface with the MMIS for provider enrollment and claim information, to create transactions for payment within the MMIS and to store payment information (check date,

payment date) within MAPIR. MAPIR has been designed to reduce the need for manual intervention, and addresses most of the edits and checks as part of the system logic. Currently, the collaborative is working on iteration 6 to MAPIR and its enhancements. MAPIR 5.0 was released to the collaborative in April 2013 for Stage I changes. Enhancements 5.1, 5.2, 5.3 and 5.4, and 5.5 have been released and implemented. Enhancement 5.2 is for Program 2014, Eligible Hospitals Stage 2 MU changes and was released to the collaborative in November 2013. Enhancement 5.3 was released in January and covers Eligible Professionals Stage 2 MU changes Program year 2014. Enhancement 5.4 was released in November 2014 and covers Eligible Hospital Stage 2 MU changes and report changes. Enhancement 5.5 was release in December 2014, and Delaware implemented it on March 9, 2015. This enhancement covers the Flexibility Rule changes. Further enhancements including 5.7.5 updated MAPIR for changes under the Modified Final Rule. We implemented MAPIR version 6.0 in Fall 2017 to upgrade for changes due to Modified Meaningful Use for 2017; the OPPS Rule and the Medicare Quality Payment Program (QPP) also referred to as MACRA/MIPS. Delaware customization and deployment of MAPIR 6.0 allowed providers to proceed with attestations under the newest rules and was available to Delaware Medicaid EHR Incentive Program participants by October 2017. MAPIR version 6.1 with associated patches was implemented beginning in March 2018. Release 6.2, which contains enhancements for MAPIR, is scheduled to be released by the Core DXC Programming group end of Q1 CY 2019. Delaware plans to employ Release 6.2 to production in June 2019.

DMMA has designed MAPIR to provide a web-based tool for administration of the Delaware EHR Incentive Program. MAPIR is an add-on to the DMES and is accessed through the DMAP provider portal. Only providers without sanctions and with a valid license are able to access the provider portal due to the existing security structure of the DMES. Internal DMMA users access MAPIR for administrative functions in accordance with state security access rules.

Features of the MAPIR include:

- Interface with the R&A System
- Eligibility Verification and Notification
- EP/EH Attestation
- Incentive Payment Calculation and Distribution
- Appeals Tracking
- User Interface for state personnel (or contractors) to be able to view, monitor, and support payment applications submitted by providers
- Provider portal to view and validate R&A System data and register and attest through submission of application

In addition, MAPIR will contain a series of edits and checks that will be used during the provider

application process (e.g., confirmation of R&A System information, patient volume, and attestations) to verify and validate the information during the process.

The MAPIR system will be used to process most of the stages of the provider application including:

- Provider Applicant Verification
- Provider Applicant Eligibility Determination
- Provider Applicant Attestation
- Provider Application Payee Determination
- Application Submittal Confirmation/Digital Signature
- Payment Determination (including R&A System confirmation)

The PIP Team, operated by the FA, supports the Delaware EHR Incentive Program. This team reviews, evaluates, tracks enrollment and attestation criteria, performs outreach and interfaces with providers, and helps upload needed documents for verification. Many of the same general processes involved in enrolling a new Medicaid provider are used.

The Division evaluated and enhanced the current Medicaid agency service operations to accommodate the EHR Provider Incentive Payment Program. Delaware DMMA found that many of the current administrative processes remained intact (for example: provider enrollment, claims processing). The current DMES financial system has been leveraged in order to make approved provider incentive payments. DMMA has addressed the customization of MAPIR and its MMIS for Delaware's specific requirements in the IAPD.

DMMA is aware of the Seven Standards and Conditions in 433Sections 1903(a)(3)(A)(i) and 1903(a)(3)(B) of the Social Security Act. This Medicaid HIT solution addresses this requirement through the following:

1) The modular MAPIR system can be reused with any future system
2) The solution conforms with our MITA roadmap and will be identified in future MITA SS-As
3) The solution uses predefined CMS communication standards for incentive reporting
4) The solution can be leveraged for future HIT initiatives and is open for sharing with other states
5) The solution supports workflow management for the Provider Incentive Payment Team to encourage timely processing of provider payments
6) The solution supports transaction level auditing and electronic reporting to management and federal agencies
7) DMMA, through Delaware's State Innovation Model grant, has a goal to develop eCQM reporting with the DHIN and to explore simplifying the Medicaid EHR MU requirements by allowing electronic reporting of these measures.

## 4..8 MAPIR Process Flow

The following High Level Flow diagram shows how the MAPIR, R&A System, and the DMMA work together to support the Delaware EHR Incentive Program.

MAPIR is the Delaware state level repository (SLR). The MAPIR Collaborative submits business requirements to the technical vendor, and the teams collaborate to establish a timeline for development, testing, and implementation.

The MAPIR workflow was redesigned to prompt a provider to enter his/her CMS CEHRT ID early in the attestation process. Based on the CEHRT ID, MAPIR determines the CEHRT Edition and present corresponding options for attestation consistent with the Flexibility Rule or other more current Rules. Providers using a CEHRT flexibility option are required to attest to a statement indicating they were unable to fully implement current versions of CEHRT.

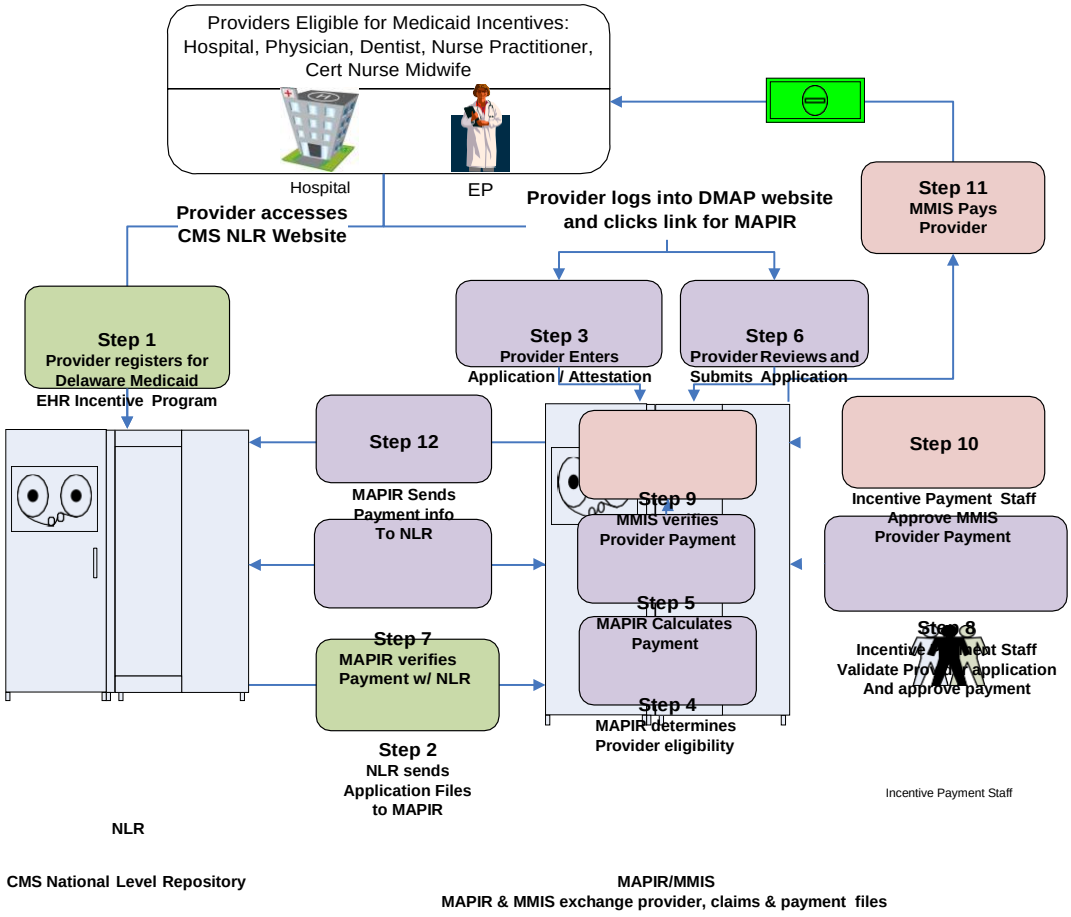



**Figure 3 Medicaid Incentive Program- High Level Overview**

### 4..8.1 MAPIR Interfaces

The MAPIR system interfaces both with the DMES and R&A System for:

- Medicaid provider information (e.g., provider files, claims)
- Information stored in federal databases concerning the provider that registered for payment at the R&A System (e.g., National Provider Identifier (NPI), Payee Taxpayer Identification Number (TIN) Information collected from providers as they apply to participate in the program (e.g., patient volumes, A/I/U attestation))

MAPIR supports the following Batch Interfaces to perform these functions:

**R&A System:**

- Provider Registration
- Registration Confirmation
- Dually EH Attestation Data
- Duplicate Payment/Exclusion Check Request
- Duplicate Payment/Exclusion Check Response
- Dually EH Cost Report date
- Incentive Payment Date

**DMES:**

- Enrolled Provider
- Claim Volume Reply
- Claim Volume Request
- Remit Advice

### 4..8.2 MAPIR, DMES, R&A System Process Flow

The high-level process flows shown in Figures 2 through 9 below address the following MAPIR, DMES and R&A System processes, primarily in sequential order:

- Login-In Possible Statuses (decision points for approval/denial)
- R&A System Registration (check for R&A System registration)
- EH Incentive Application (review of enrollment for hospitals in MAPIR)
- EP Incentive Application (review of enrollment for health professionals in MAPIR)
- Expired (process when an application has not been completed within a specific time)
- Adjustments (process for appeals for program participation and payment level)
- Pend/Deny Questions (process for review and denial of submitted applications)
- R&A System Update Received Process

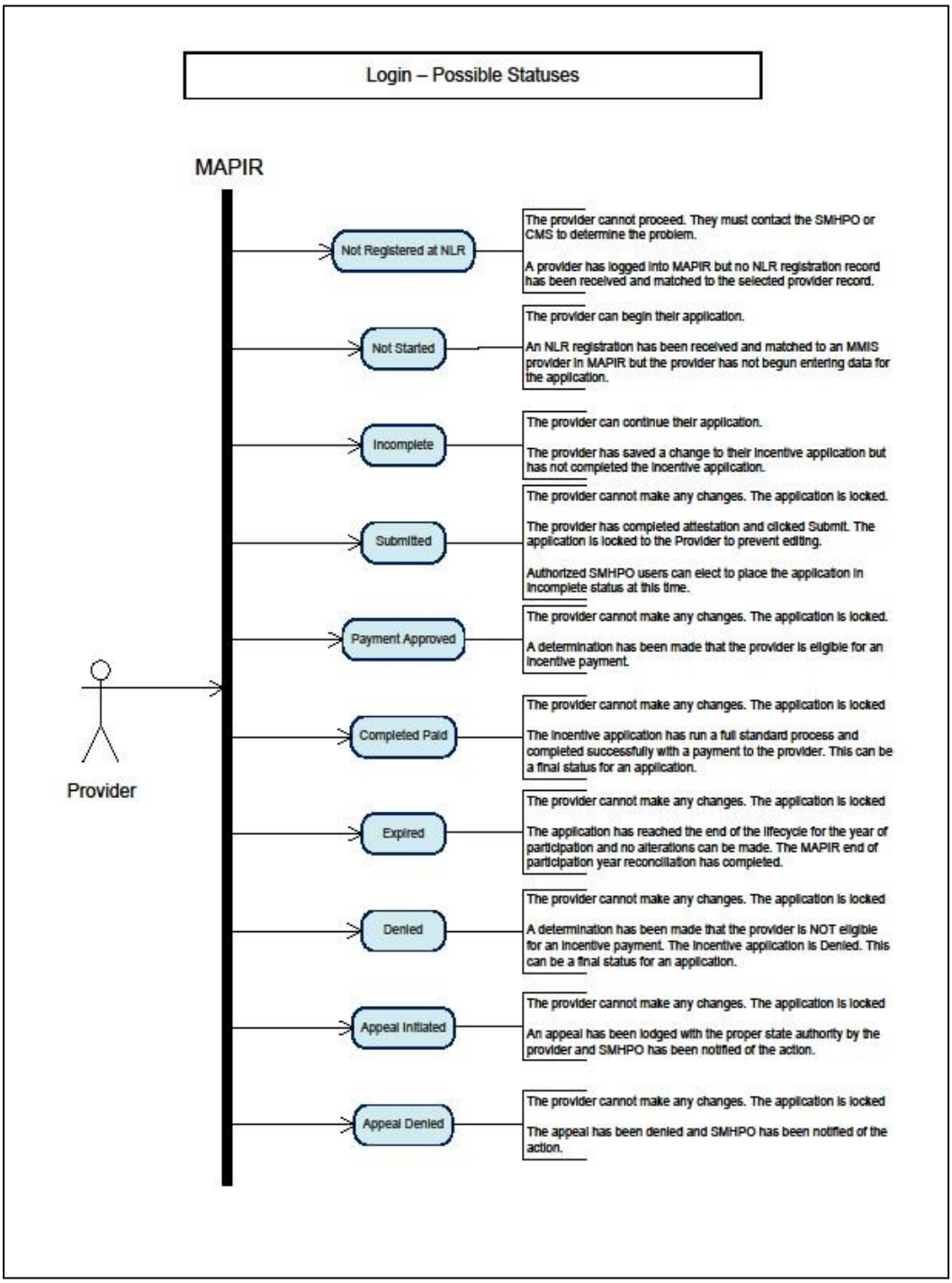



**Figure 4 MAPIR: Log-in Possible Statuses**

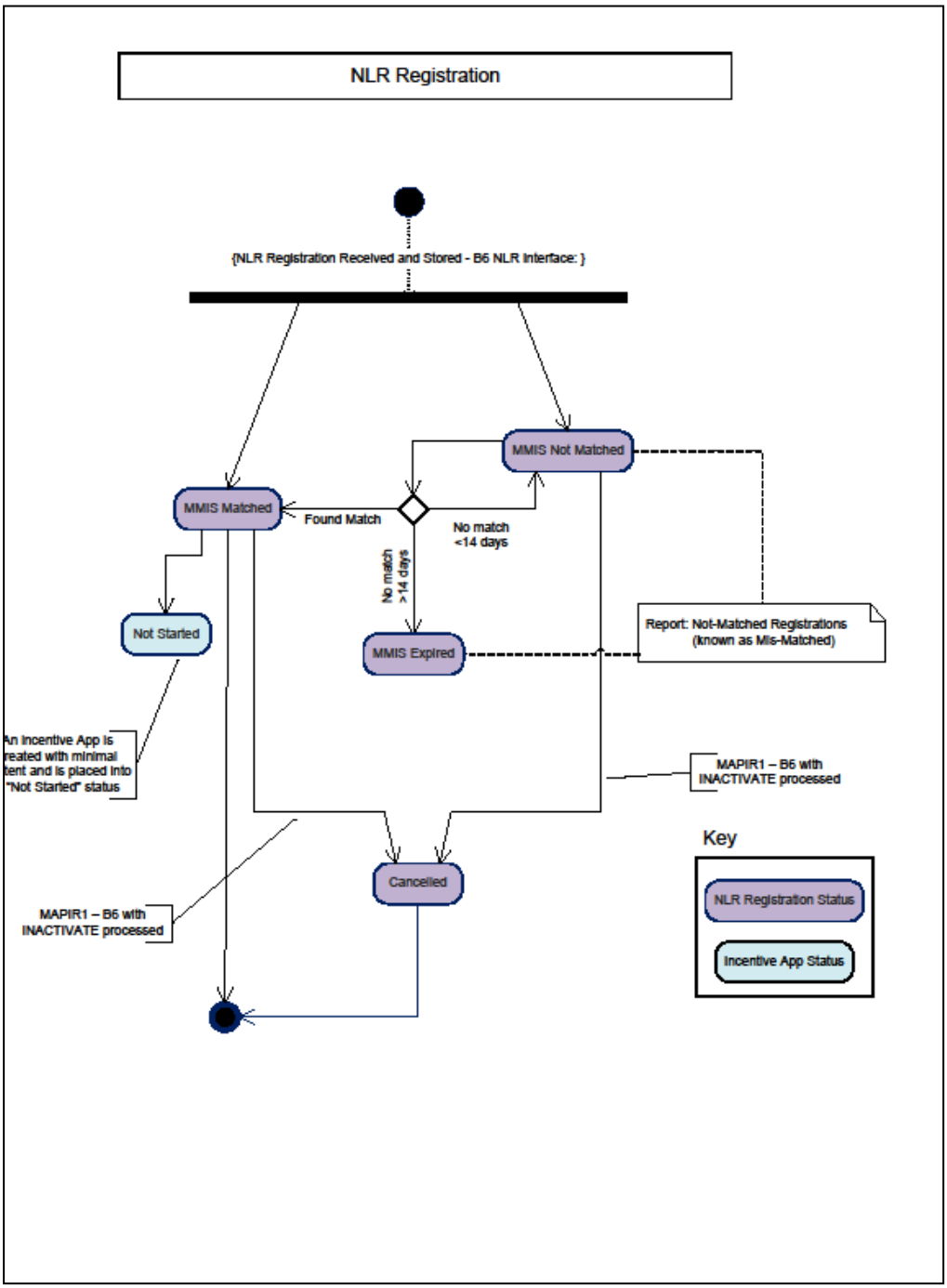



**Figure 5 MAPIR: R&A System (National Level Repository (NLR)) Registration**

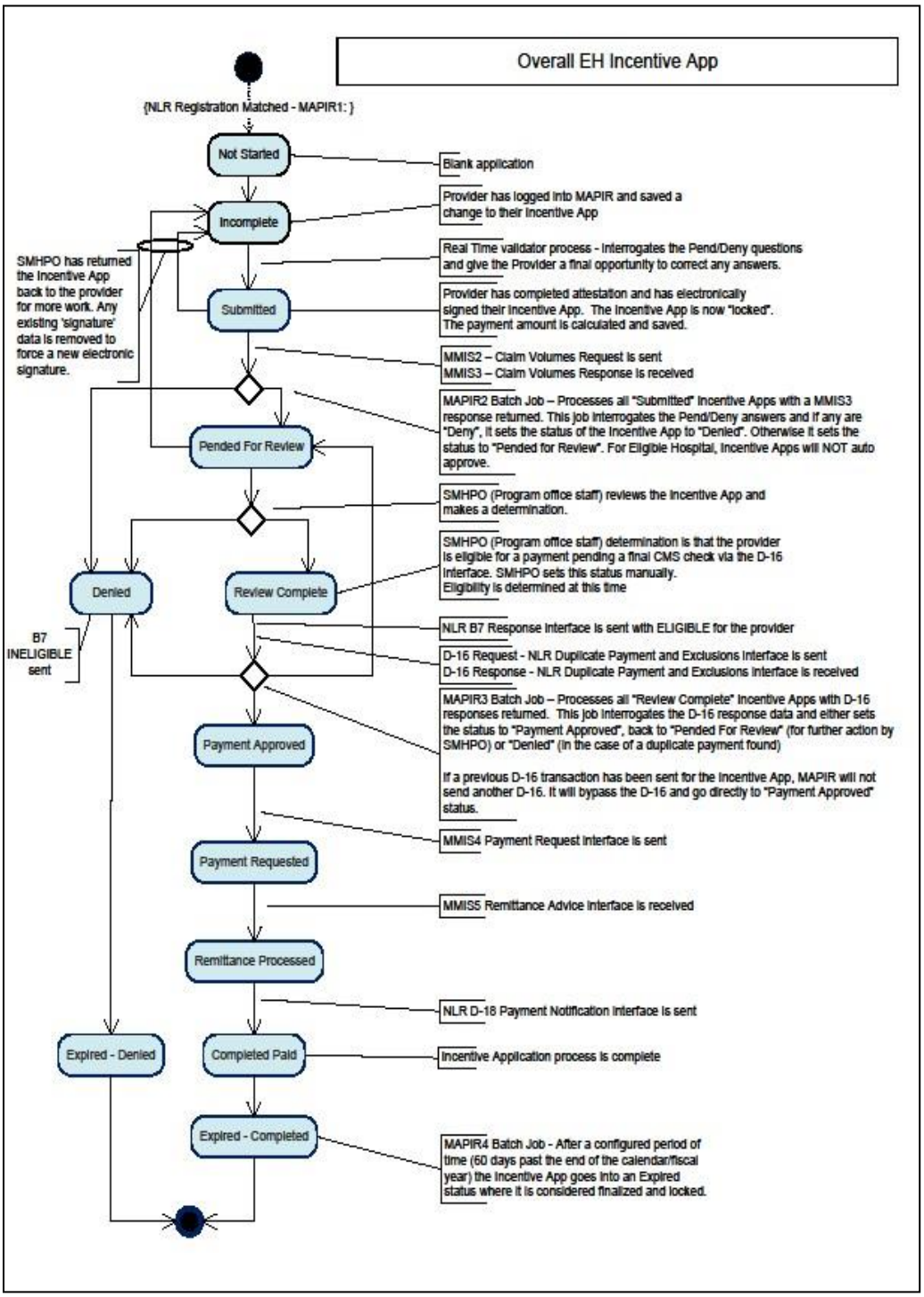



**Figure 6 MAPIR: Overall EH Incentive Application Process**

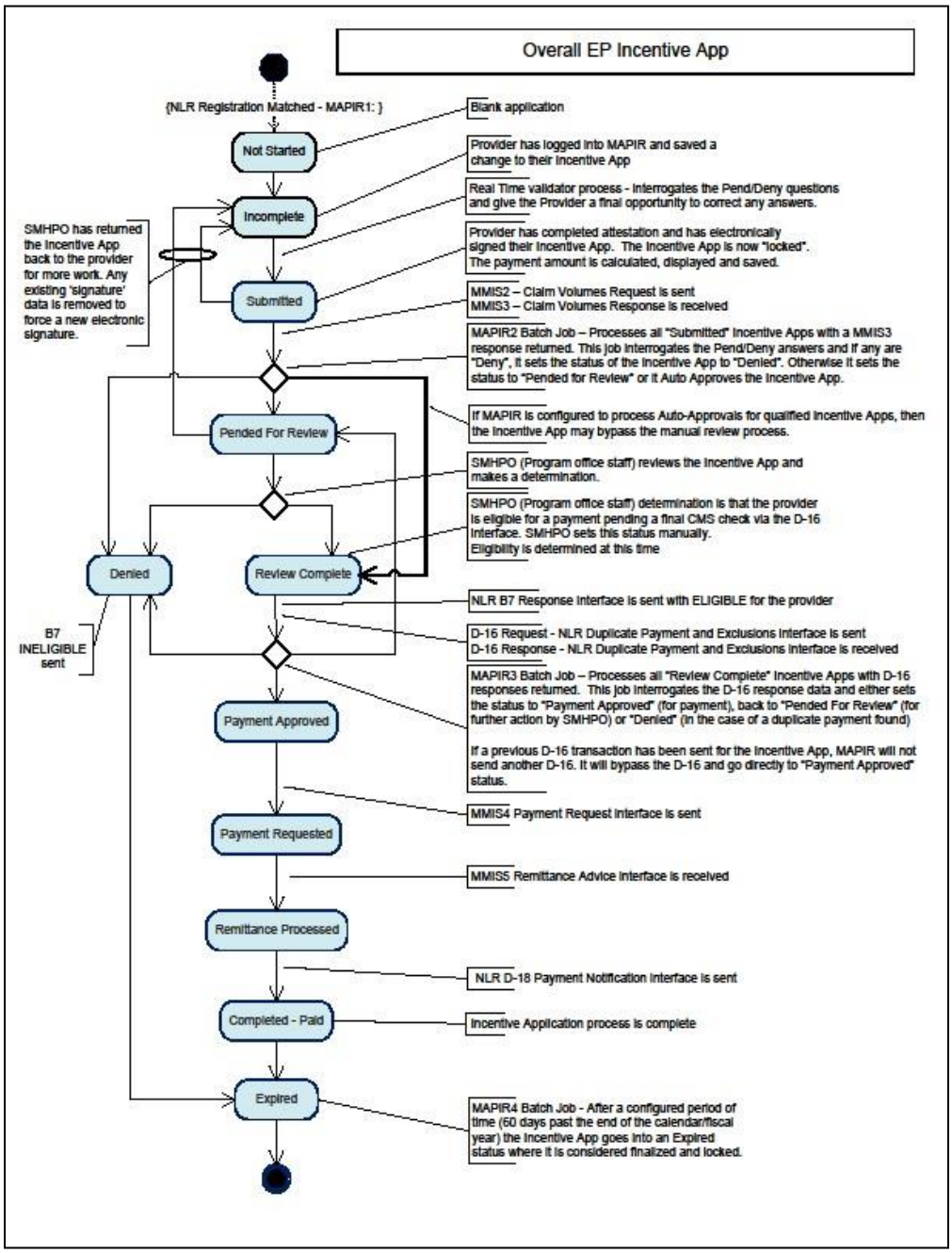



**Figure 7 MAPIR: Overall EP Incentive Application Process**

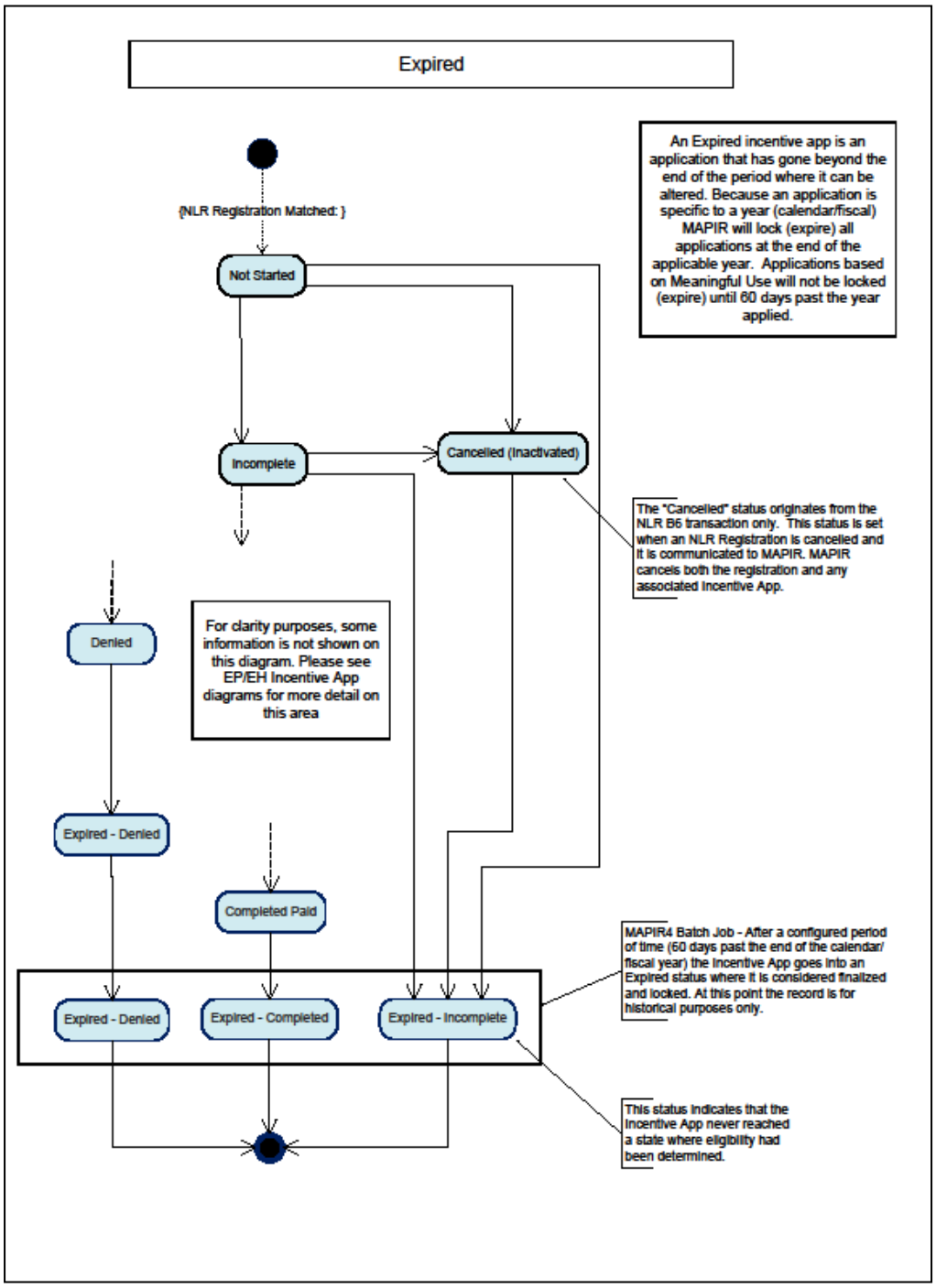



**Figure 8 MAPIR: Expired Applications Process**

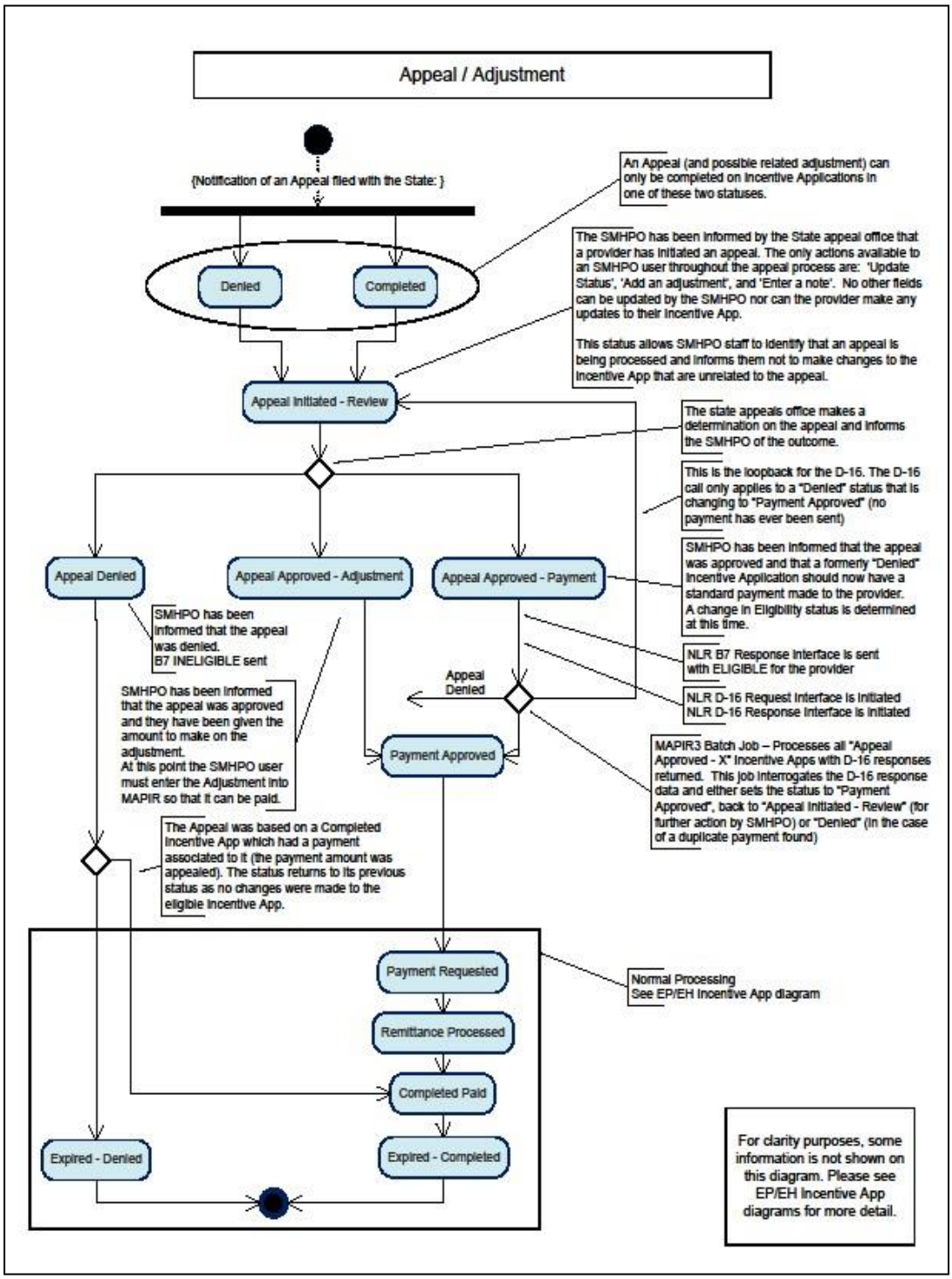



**Figure 9 MAPIR: Appeal/Adjustment Process**

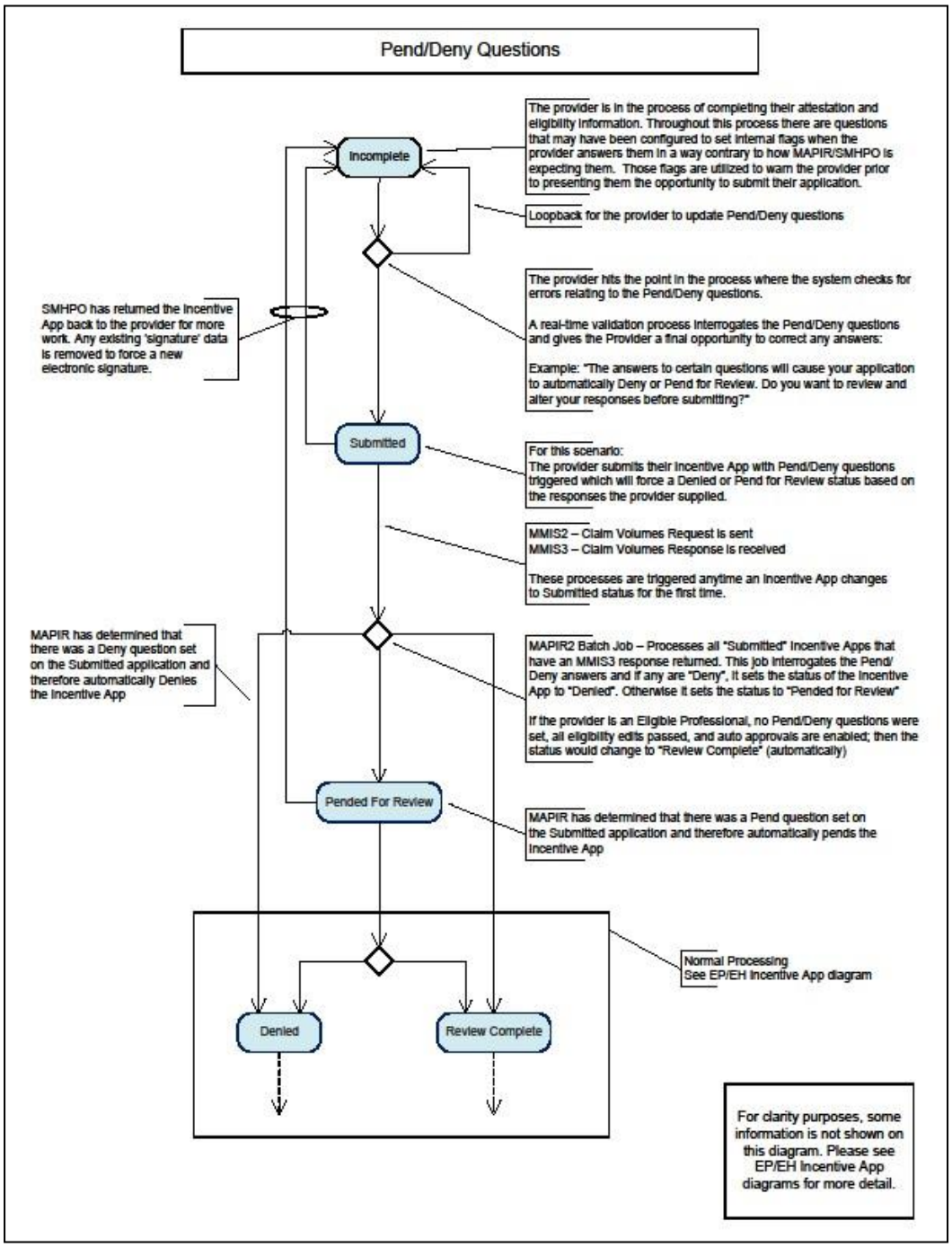



**Figure 10 MAPIR: Pend/Deny Questions Process**

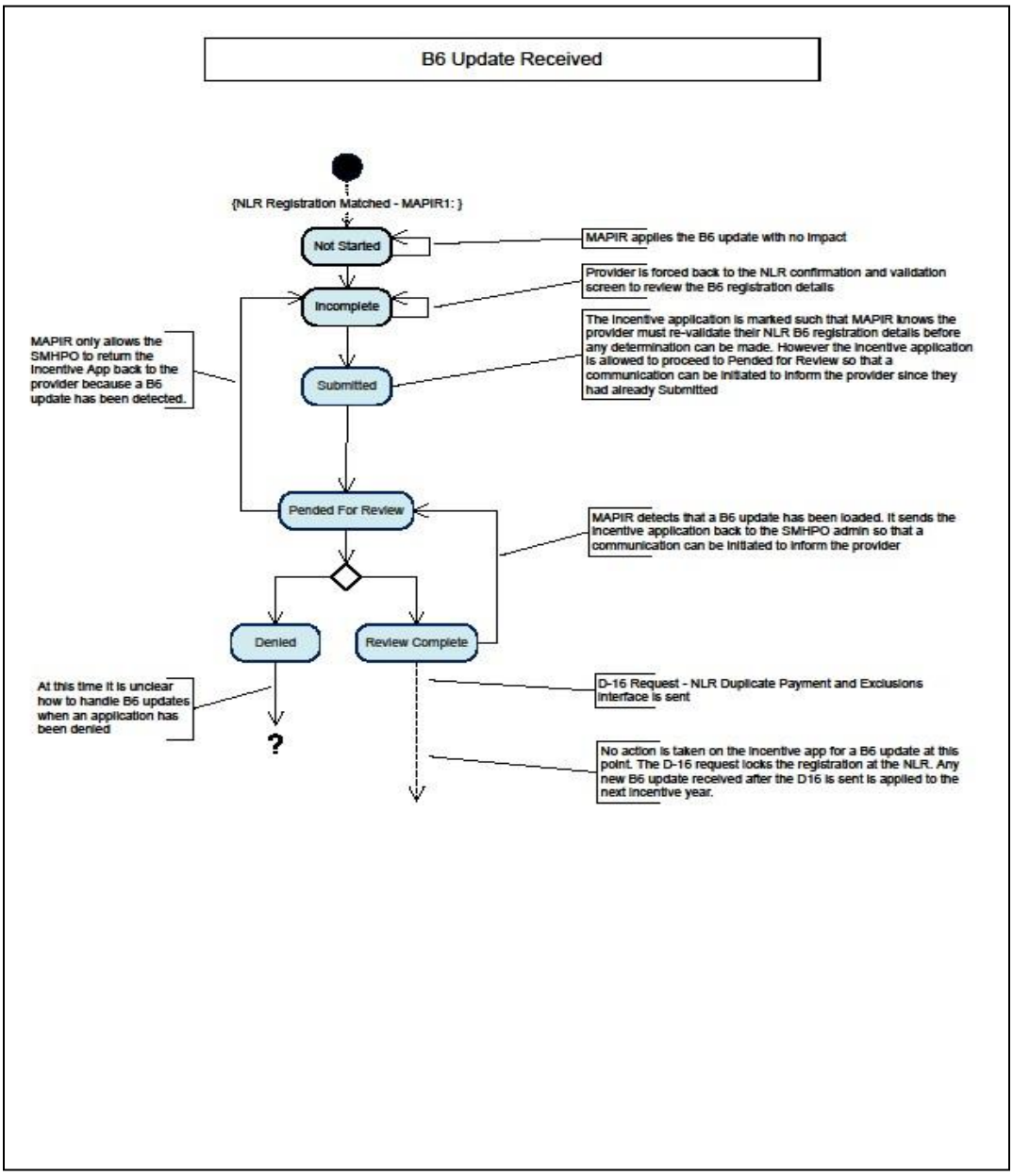



**Figure 11 MAPIR: R&A System (NLR) Update Received Process**

### 4..8.3 R&A System Provider Registration

Providers must first complete the R&A System registration at CMS before registering for payments from the Delaware EHR Incentive Program. MAPIR receives a file of registered providers from the R&A System on a daily basis. This file contains all new providers registering to receive an incentive payment from Delaware Medicaid. The file also contains any providers that have made updates to their R&A System registrations.

The R&A System collects the following information from providers:

- NPI: NPI where the source system is the National Plan and Provider Enumeration System (NPPES)
- Provider Transaction Access Number (PTAN)/CMS Certification Number (CCN): Provider number (for hospitals)
- Payee TIN: TIN to be used for payment
- Personal TIN: Personal TIN (EPs)
- Record Number: A unique identifier for each record on the interface file
- Program Option: EP's choice of program to use for incentives. Valid values include Medicare or Medicaid. For Hospitals, a selection of Dually Eligible will be available.
- State: The selected State for Medicaid EHR Incentive Program participation
- Provider Type: Differentiates types of eligible providers

Key file attributes such as the NPI and TIN and/or CCN will be compared with similar provider information received from the state MMIS to determine a match.

Providers indicate whether they wish to assign their incentive payment (and, if so, to whom they wish to assign it) in the R&A System. The R&A System also interfaces with other sources of provider information including the Medicare Exclusions Database, which helps to identify providers who are ineligible due to exclusions or sanctions.

Delaware EHR Incentive Program Registration and Attestation Process

All providers must first be enrolled in the DMAP program to participate in the Delaware EHR Incentive Program. Most eligible providers are already enrolled in DMAP but some providers that are only enrolled with a Medicaid MCO may not be. To gain access to the provider registration portal and receive incentive payments, these providers must enroll with DMAP before they can begin the application process.

After registering with the R&A System, the provider begins the application process for the Delaware Medicaid EHR Incentive Program. Providers access MAPIR and initiate the process through the DMAP Secure State Portal. MAPIR first checks the R&A System to confirm that the provider is registered with CMS. If the provider is not registered in the R&A System, they will be notified to register before proceeding. If R&A System information exists and matches, the provider can proceed to the application process.

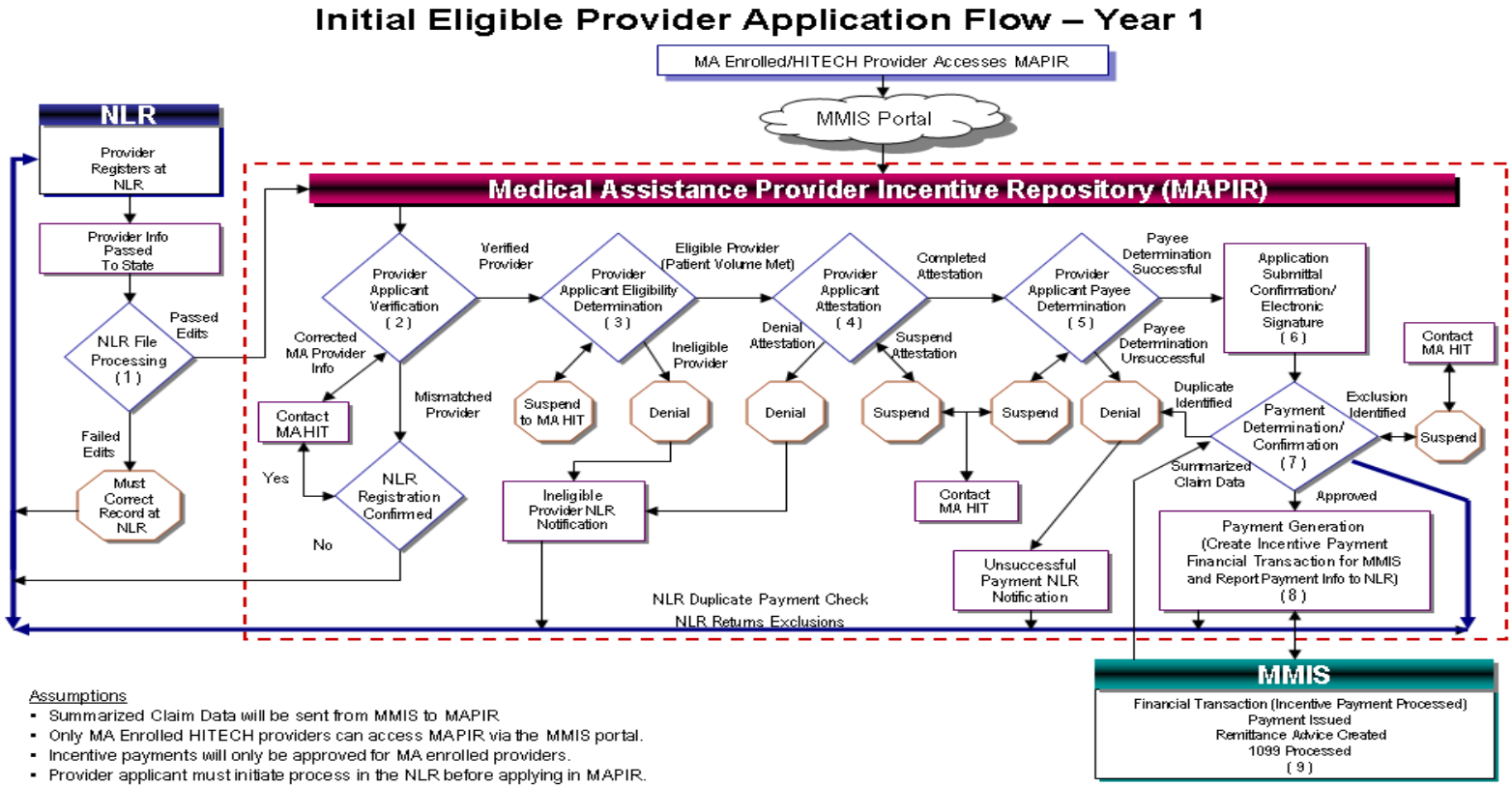
MAPIR will collect the following additional information as part of the application process:

- Provider type and specialty
- Attest not hospital-based (EPs only)
- EHR Certification Number
- Patient volume
- Proof of A/I/U/MU
- Growth rate (hospitals only)
- Medicaid share (hospitals only)

The provider completes all required fields in MAPIR and submits the application (see the MAPIR process flows in Section 4.6.3). All data fields are electronically validated in real-time for completion and appropriate formats. During the entry of application data in MAPIR, a real-time validator process interrogates the answers to questions and gives the provider a final opportunity to correct any answers that could impact the approval process. Providers see a list of potential errors and have the opportunity to review their entries. This gives the provider an opportunity to re-evaluate an answer for validity. MAPIR automatically alerts the provider of the status of their application throughout the process, such as when the application has been approved, denied, canceled, and when payment has been issued.

All applications reviewed by DMMA will be pended. When final review and verification is complete, the application status is changed to review complete and designated as approved or denied. MAPIR produces a daily summary application status report for review showing the number of applications submitted, pending, and approved/denied for monitoring by Provider Relations staff and the Medicaid HIT coordinator. Prior to payment, a second R&A System check is performed to confirm no other payments have been issued. Then payment is approved and processed electronically. Once issued, the provider is notified that payment is forthcoming.

The graphics in Figures 10 and 11 below provide a summary view of the MAPIR EP and EH process flows.

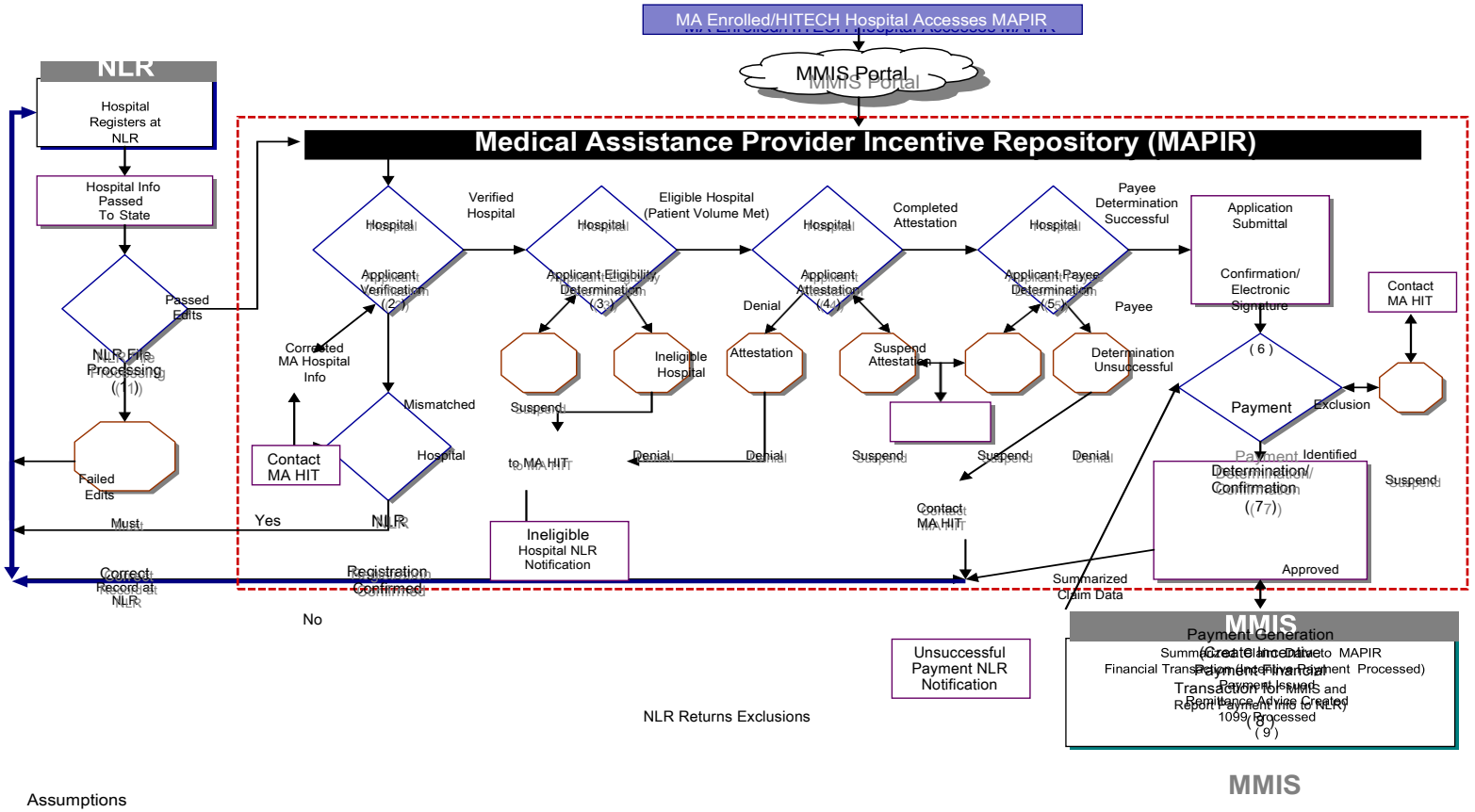



Assumptions

- Summarized Claim Data will be sent from MMIS to MAPIR
- Only MA Enrolled HITECH providers can access MAPIR via the MMIS portal.
- Incentive payments will only be approved for MA enrolled providers.
- Provider applicant must initiate process in the NLR before applying in MAPIR.
- Provider Applicant Eligibility Determination process will not be able to begin until the MAPIR record is error free.
- Eligibility and payment information will be sent to the NLR. NLR will be checked prior to release of financial transaction to the MMIS to avoid duplicate payments.

**Figure 12 Initial Eligible Provider Application Flow - Year 1**

## Initial Eligible Hospital Application Flow – Year 1




Assumptions

- Summarized Claim Data will be sent from MMIS to MAPIR
- Only MA Enrolled HITECH hospitals can access MAPIR via the MMIS portal.
- Incentive payments will only be approved for MA enrolled hospitals.
- Hospital applicant must initiate process in the NLR before applying in MAPIR.
- Hospital Applicant Eligibility Determination process will not be able to begin until the MAPIR record is error free.
- Eligibility and payment information will be sent to the NLR. NLR will be checked prior to release of payment transaction to MMIS to avoid duplicate payments.
- Hospital payment calculations for dually eligible hospitals will be verified with Medicare Cost data received from the NLR

**Figure 13 Initial EH Application Flow – Year 1**

## 4..9 Provider Eligibility for Incentive Payments

The specifications and methodology for the provider eligibility criteria required for enrollment and re-enrollment to the Delaware EHR Incentive Program are described below. Provider Eligibility Determination

Once the provider has completed the application and attestation, MAPIR displays an application summary, which includes the R&A System information displayed on first page of the application, indicator of provider type, Medicaid patient volume percentage calculation, and whether they are adopting, implementing, or upgrading or attesting to meaningful use.

MAPIR generates an automated list of pending applications daily which the PIP Team will use to complete the eligibility determination process. The Team reviews all “suspending” or “pending” applications and follows up with the applicant, as necessary. MAPIR is interactive so that the PIP can update the MAPIR with their determinations, enter notes, and complete selected fields. The

Providers that are not active, become inactive, or are excluded from the Medicaid program are not able to complete an incentive application. Provider portal activity is only allowed for active, non-excluded providers. Therefore, any provider that is deactivated due to, for example, a match in the state sanctioned database or due to a death match cannot have their application data updated.

MAPIR supports eligibility and attestation screens to accommodate MU stages and year of application for the provider. A review process is completed to validate the eligibility of each participating provider and ensure that MU requirements are met prior to payment. The PIP Team validates the eligibility of each participating provider. The process incorporates reviews of:

- Continuing provider eligibility on all criteria
- Variance in patient volumes
- New information in the R&A System
- MU criteria measures
- Continued participation as Medicaid provider

During the application, MAPIR validates the CMS EHR certification number for validity.

Upon approval and before payment, MAPIR automatically validates with CMS that the provider is still eligible by ensuring that the provider has not received payment through another incentive program source, such as Medicare.

Providers must verify all program eligibility requirements each year in order to receive their EHR Incentive payment for that year. Each year’s application advances to a point where it is denied, complete, or incomplete. Incomplete applications are ones that are not finished or have been canceled by the provider and therefore never reached a state where eligibility had been determined. Because an application is specific to a single year, MAPIR locks (expires) all applications at the end of the applicable year.

Applications based on MU are not to be locked until 60 days past the application year to provide adequate time to report the MU values. Delaware allows EPs a grace period at the end of the calendar year of 60 days (January 1 – February 28/29) and EHs a grace period at the end of the Federal Fiscal Year of 120 days (October 1 – December 31). The previous year's application must be labeled as expired for the provider to apply the next year. For Program Year 2015 attestations only, the grace period was increased to a 90 day period (January 1 – March 30, 2016) to allow providers to attest under the flexibility rule.

For Program Year 2014 attestations, the grace period for Eligible Professionals as extended to June 30, 2015. This allowed Delaware Medicaid EHR Incentive Payment providers more time to complete 2014 applications. For Eligible Hospitals (EHs), the grace period for submitting 2014 Delaware Medicaid EHR Incentive Payment hospital applications was extended until March 31, 2015.

Based on the timeline to test and launch the Delaware Medicaid Enterprise System (DMES), Program Year 2015 MU applications will be accepted in MAPIR, the State Level Registry, on September 1, 2016 until October 31, 2016. Program Year 2016 AIU and MU applications will be accepted January 9, 2017 until April 30, 2017.

In August 2018 we finalized Program Year 2017 applications for payment with a Grace Period ending on April 1, 2018. The MAPIR portal will accept Program Year 2018 applications beginning August 2018. We plan to end the Grace Period on March 31, 2019.

Providers will continue the registration process in subsequent years at the R&A System and a new application process requires existing providers to validate and submit the necessary information for the subsequent program year. Providers are not required to participate in the program in consecutive years, so a follow up review process is conducted when the provider requests a second or subsequent incentive payment. The years of incentive payment are tracked so that the correct payment is approved and the appropriate number of payments is disbursed.

The PIP Team, in conjunction with PI, will be responsible for auditing and verification of information submitted in applications and attestation forms, and will collaborate on conducting payment reviews.

#### 4..9.1.1 Patient Volume Determination

All EPs enter their patient volumes via MAPIR. Those that are not pediatricians need to demonstrate a 30 percent Medicaid patient volume to be eligible for an incentive payment. A pediatrician is only required to demonstrate a Medicaid patient volume between 20 percent and less than 30 percent to be eligible. However, pediatricians also receive a reduction in their payment amount.

If an EP does not meet the 30 percent Medicaid patient volume or the 20-29 percent needed for a pediatrician to be eligible for an incentive payment, MAPIR displays a configurable dispositional edit that allows a state to set the outcome of the application as pend, deny, or no action.

If patient volume is between 20 percent and 30 percent, a health professional that seeks to use the pediatrician volume should have a pediatrician or neonatology taxonomy. Currently, a provider that seeks to use the pediatrician volume but does not have pediatrician taxonomy is denied. DMMA will require all pediatricians to provide proof of license. If a physician assistant applicant practices predominantly in an FQHC/RHC, the applicant completes a patient volume table that includes counts of needy individuals as well as locations, numerator, and denominator. If the physician assistant applicant does not practice predominantly in an FQHC/RHC, the provider completes a separate patient volume table with locations, numerator, and denominator. The system calculates patient volumes and suspends applications that do not meet the patient volume requirements. EPs may use a six-month period within the prior calendar year or preceding 12 month period from the date of attestation for the definition of practicing predominantly (more than 50% of the encounters).

ACHs are asked to enter their Medicaid and total discharges for the prior FFY. Acute care and children's hospitals' Medicaid and total discharges are listed on the hospitals' cost reports. DMMA takes the numbers from the cost reports in order to verify the information entered by the hospitals.

### 4..9.2 Eligible Providers

The first tier of provider eligibility for the Delaware EHR Incentive Program is based on taxonomy. If the provider type and specialty for the submitting provider in the Delaware MMIS provider data store does not correspond to the taxonomy approved for participation in the Delaware EHR Incentive Program, the provider will receive a message to indicate denial. At this time, the following providers and hospitals are eligible to enroll in the Delaware EHR Incentive Program:

- Physicians
- Pediatricians
- Nurse Practitioners
- Certified Nurse Midwives
- Dentists
- ACHs
- Children's Hospitals

Delaware does not have any CAHs or FQHCs/RHCs led by a Physician Assistant, so these eligibility categories are not applicable in the State at this time.

Provider eligibility will be based on the taxonomy code associated with the registering provider in DMES. EP types and specialty codes for Delaware Medicaid are listed in Table 10 below:

**Table 10 Eligible Taxonomy Codes**

| Medicaid Taxonomies (As of 02/01/2017) | | | |
|---|---|---|---|
| Physician Specialties | | Physician Specialties | |
| **Taxonomy** | **Specialty** | **Taxonomy** | **Specialty** |
| 1223P0106X | Oral Pathology | 207U00000X | Nuclear Medicine |
| 1223S0112X | Surgery/Oral | 207V00000X | Gynecology & Obstetrics |
| 207KA0200X | Allergy | 207W00000X | Ophthalmology |
| 207L00000X | Anesthesiology | 207X00000X | Surgery/Orthopedic |
| 207N00000X | Dermatology | 207Y00000X | Otolaryngology |
| 207Q00000X | Family Practice | 207ZP0101X | Pathology |
| 207QA0000X | Family Practice, Adolescent | 208000000X | Pediatrics |
| 207QA0505X | Family Practice, Adult | 2080A0000X | Pediatrics, Adolescent |
| 207QG0300X | Gerontology | 2080N0001X | Neonatology |
| 207R00000X | Internal Medicine | 208100000X | Physical Medicine/Rehab |
| 207RA0000X | Internal Medicine, Adolescent | 208200000X | Surgery/Plastic |
| 207RC0000X | Cardiology | 2084N0400X | Neurology |
| 207RE0101X | Endocrinology | 2084P0800X | Psychiatry |
| 207RG0100X | Gastroenterology | 2085R0202X | Radiology |
| 207RG0300X | Internal Medicine, Geriatric | 2085R0203X | Radiation Therapy |
| 207RH0003X | Hematology | 208600000X | Surgery/General |
| 207RI0200X | Infectious Disease | 2086S0129X | Surgery/Cardiology |
| 207RN0300X | Nephrology | 208800000X | Urology |
| 207RP1001X | Pulmonary Disease | 208C00000X | Surgery/Colon & Rectal |
| 207RR0500X | Rheumatology | 208D00000X | General Practice |
| 207RX0202X | Oncology | 208G00000X | Surgery/Thoracic |
| 207T00000X | Surgery/Neurological | 261QS1200X | Sleep Disorder Diagnostic |

| Nurse Specialties | | Dental Specialties | |
|---|---|---|---|
| **Taxonomy** | **Specialty** | **Taxonomy** | **Specialty** |
| 363L00000X | Certified Registered Nurse Practitioner | 122300000X | Dentist |
| 367A00000X | Nurse Midwife | 1223X0400X | Orthodontist |
| 1223P0221X | Pediatric dentistry | 1223E0200X | Endodontics |
| 1223P0300X | Periodontics | | |

Providers and hospitals that are currently NOT eligible for the Delaware EHR Incentive Program, unless they meet one of the other currently eligible taxonomies, include behavioral health (substance abuse and mental health) providers and facilities, and LTC providers and facilities. Note that some taxonomies that are eligible for the Medicare program, such as podiatrists, chiropractors, and optometrists, are not eligible for the Medicaid EHR Incentive Program.

### 4..9.3 Patient Volume Calculation

DMMA adopted option #1 from the final rule and requires the use of encounters only to calculate patient volume.

Delaware Medicaid and Stage 1 Final Rule defined an encounter as any one day where Medicaid paid for all or part of the service or Medicaid paid the co-pays, cost-sharing, or premiums for the service.

Stage 2 Final Rule changed the definition of an encounter (applicable to all stages as of program year 2013) as services rendered on any one day to a Medicaid-enrolled individual, regardless of payment liability including zero-pay claims:

- Zero-pay claims can include but are not limited to:
- Claim denied because the Medicaid beneficiary has maxed out the service limit;
- Claim denied because the service wasn't covered under the State's Medicaid program;
- Claim paid at $0 because another payer's payment exceeded the Medicaid payment;
- Claim denied because claim wasn't submitted timely.

Such services can be included in provider's Medicaid patient volume calculation as long as the services were provided to a beneficiary who is enrolled in Medicaid.

Although EPs may not collect Medicaid EHR incentive payments from more than one State, if an EP practices in two locations, one with certified EHR technology and one without, the EP should include the patient volume at least at the site that includes the certified EHR technology. When calculating individual Patient V (i.e., not using the group/clinic proxy option), an EP may calculate across all practice sites, or just at the one site.

MCOs must provide provider encounter detail to Medicaid for services that are performed by a provider in an MCO but that are reported under the group and not the individual provider to Medicaid. In these cases, the PIP Team requests a list of individual provider encounters from the MCO. Delaware may explore the use of panels in the future for programs such as the Program of All-Inclusive Care for the Elderly (PACE) but currently does not plan to use panels for volume calculation. We do not currently use panel volume; and per Stage 2, the time period between encounters with a patient is now 24 months and can be included if DE should begin to use panel volume. This is a change from 12 to 24 months to account for new clinical guidelines from the U.S. Preventive Health Services Task Force that allow greater spacing between some wellness visits. Delaware will not implement panel volume in year 2.

Providers will be able to choose a contiguous 90 day period from either the prior calendar year OR the preceding 12 month period from the date of the attestation. The change is effective January 1, 2013 for EPs and October 1, 2012 for EHs, and will carry through subsequent years. EPs attesting as participating in a Federally Qualified Health Center (FQHC) or a Rural Health Center (RHC) can also use either time frame method when demonstrating 50% of their encounters were at a FQHC/RHC over a 6 month period.

Volume thresholds are calculated using as the numerator the hospital's or EP's total number of Medicaid member encounters for a contiguous 90 day period from either the prior calendar year OR the preceding 12 month period from the date of the attestation to include service rendered on any one day to a Medicaid-enrolled individual, regardless of payment liability (this includes zero paid claims) and the denominator as all patient encounters for the same EP or hospital over the same contiguous 90 day period from either the prior calendar year OR the preceding 12 month period from the date of the attestation . Per CMS 495.306, CHIP encounters cannot be included in the patient volume if CHIP is a stand-alone Title XXII program. Since Delaware physicians are unable to differentiate between CHIP and Medicaid patients, EPs will report a combined total. Any provider that appears eligible will have their actual CHIP encounter volume extracted from MMIS claim data and deducted from the provider reported volume by DMMA after application submission. The new calculated volume will be compared to the Medicaid volume on record. On average, CHIP contributes about two percent to the total claim volume and is three percent of DMMA's client volume. Therefore, the patient volume calculation for Delaware is as follows:

***[Total (Medicaid) patient encounters in a contiguous 90 day period from either the prior calendar year OR the preceding 12 month period from the date of the attestation. Total CHIP encounters in that same 90-day period/Total patient encounters in that same 90-day period or preceding 12 month period from the date of the attestation] * 100***

The Division will contact neighboring states if the provider indicates that he/she has significant patient volume from out of state and if the patient volume is not reasonable based on the claim count in the DMMA MMIS. For example, if the provider indicates he/she had 1000 encounters and MMIS reporting identifies only 200 encounters, the provider will be requested to provide proof of this patient volume at the same time DMMA is contacting bordering states for corroboration. In the case of a post-payment audit, it is the responsibility of the provider to verify his/her patient volume numbers.

### 4..9.4 Assuring Providers Are Not Hospital-Based

EPs must attest that they are not hospital-based. Professional claims for the reporting period will be analyzed, with the provider's NPI in the rendering provider field, to look at the place of service submitted on their claims. Since the definition of "hospital-based" includes inpatient or ER settings, DMMA will use only Place of Service Codes for Inpatient Hospital and ER as a basis for establishing "hospital-based" services. Analysis will be made of professional and institutional claims (and dental claims, for dental providers) to verify where their Medicaid member services are being rendered. If the predominant (i.e., 90 percent) place of service is the inpatient hospital or ER, DMMA will deem the provider to be hospital-based and ineligible to receive Delaware EHR Incentive Program payments.

Beginning with payment year 2013, an EP who meets the definition of hospital-based (90% or more of their attested Medicaid encounters are performed in POS 21 and/or 23), but who can demonstrate to CMS that the EP funds the acquisition, implementation, and maintenance of Certified EHR Technology, including supporting hardware and interfaces needed for meaningful use without reimbursement from an eligible hospital or a Critical Access Hospital (CAH), and uses such Certified EHR Technology in the inpatient or emergency department of a hospital (instead of the hospital's Certified EHR Technology) may be determined by CMS to be a non- hospital based EP. This determination is via an administrative process. If an EP is determined non-hospital based through this process, in subsequent payment years the EP must attest to continuing to meet the exception.

### 4..9.5 Needy Individual Patient Volume

EPs who do not meet the Medicaid PV threshold may qualify by meeting the definition of practicing predominantly as stated in 42 CFR 495.302. Practices predominantly means an EP for whom the clinical location for over 50 percent of his or her total patient encounters over a period of six months (within the most recent calendar year or, as an optional State alternative beginning for program year 2013, within the 12-month period preceding attestation) occurs at a federally qualified health center (FQHC) or rural health clinic (RHC). This also applies to Indian Health Service clinics. EPs who meet this definition can use their needy individual encounters to meet the 30% threshold for patient volume.

Needy individual encounters are defined as encounters in which Medicaid:

- Paid for part or all of the service;
- The service was rendered to a Medicaid-enrolled individual;
- Paid all or part of the individual's premiums, copayments, or cost-sharing;
- The services were furnished at no cost; and calculated consistent with §495.310(h) of the final rule or;
- The services were paid for at a reduced cost based on a sliding scale determined by the individual's ability to pay;
- The individual participates in the stand alone Title XXI CHIP program;

EPs practicing in FQHCs and RHCs may calculate PV by substituting Medicaid patient encounter data for needy individual data in the numerator in the encounter or patient panel methodologies.

### 4..9.6 Ensuring Providers are Licensed/Not Sanctioned

DMMA's existing process for provider licensure and sanctions verification will assure that only valid providers can apply for the EHR incentive Program. All providers at the time of enrollment, revalidation and annual disclosure into Delaware Medicaid are processed through LexisNexis. The LexisNexis real-time interfacing service will verify the following at the time of application submission:

NPI

Social Security Death Master File

Tax Identification

Name

Professional Licensure Boards

OIG/SAM

CMS PECOS site is checked manually.

Once a month, the Provider Licensure Board interfaces with the MMIS to update license information and status for Delaware Medicaid providers. Annually, providers are required to logon and disclose criminal and licensure issues for DMMA review. Failure to do so results in provider termination. Provider portal activity is only allowed for active providers. Therefore, any provider that is not in an active status will not be able to access MAPIR and complete an application for the EHR incentive program.

### 4..9.7 Call Center Support

The Division will use the existing Provider Relations Call Center Operations to respond to questions from EPs and EHs about the Delaware EHR Incentive Program through the PIP Team. DXC will provide operational support and technical assistance to EPs and EHs as they navigate through the Delaware EHR Incentive Program. DXC will also provide education and support when responding to provider telephone calls, correspondence, and emails related to the Delaware EHR Incentive Program. Call Center staffing will be augmented for this additional workload. Calls will be received and responded to using the existing standard MITA Manage Provider Communications business process.

PIP representatives will be trained on the Delaware EHR Incentive Program processes and rules (e.g., eligibility, attestation, enrollment and registration, R&A System/MAPIR, submission of MU data, appeals, and incentive payments to providers) to ensure they are able to provide whatever assistance providers need. Standard procedures and FAQs will be prepared for consistency to support implementation and ongoing Incentive Program operations.

The Division EHR Incentive staff and PIP Team will assist providers with state-specific Incentive Program questions, questions on the state application, and provide outreach materials. The REC will assist by directing providers to the R&A System for registration questions or to DMMA's web site/call center for state-specific incentive payment questions. The REC and DMMA will publish on their web sites information regarding online eligibility and will provide the call-center number prominently in their posting as well as in all marketing materials produced by the REC or in collaboration with DMMA. The REC continues to assist providers in Delaware with incentive payment applications, however, there is now a fee for the service.

## 4..10 Processing Payments to Providers

The section describes the processes involved to calculate, approve, and generate Delaware EHR Incentive Program provider and hospital payments.

Once DMMA has approved the provider's eligibility to participate in the Delaware EHR Incentive Program and the provider payment is approved, a payment transaction is sent to DMES. The DMES will revalidate the NPI, CCN (hospitals), or Payee TIN prior to issuing the payment. If an error is found in the process, the application will be flagged for DMMA review. MAPIR creates a daily approved payment transaction file, which contains payment information for provider applications that have reached "Ready for Payment" status, including the approved EHR Incentive payment amount. A new DMES batch process was developed to retrieve this file from the MAPIR file system and use the information in the file to create Incentive payment request records for loading into the DMES database in a pending status. On a weekly basis, the pending EHR Incentive payment requests are compared to the requests previously added to the DMES. New payment requests that appear to be duplicates of previous requests are flagged for review as potential duplicates and reported on an EHR Incentive Payment Request Exception report. Any requests for recoupment or adjustments are also verified to ensure that the original payment has not already been recouped or adjusted, and any exceptions are also reported on the new EHR Incentive Payment Request Exception report.

The Incentive Payment Request Management (IPRM) screen allows DXC to review the EHR Incentive Payment requests in pending or review status and take appropriate action (no action, hold, or approve for processing). If no action is taken prior to the weekly financial cycle, the request remains pending and will not be processed. Any request in error status will never be processed in the DMES financial cycle. In the DMES system to Go-Live on January 1, 2017, an Incentive Payment (IP) panel in the financial sub-system will allow DXC to review the EHR Incentive Payment requests in pending status. The IP Expenditure panel in the DMES system will allow State or DXC PIP Team staff to approve a pending incentive payment and send it through the weekly financial cycle for processing to payment.

A new weekly financial process was developed to select all EHR Incentive payment transactions that have been approved to be processed in the DMES weekly financial cycle and use the data in those requests to create the appropriate financial cash transaction records for the DMES financial subsystem. Payments are processed and paid weekly on the normal DMES payment cycle under a separate funding source to ensure EHR Incentive payments are kept separate from other weekly provider payments. A new line item for this payment was added to the 835 RA document sent to the provider. Incentive payment errors may be offset in subsequent Incentive payments and recoupment may be made from other types of Medicaid payments.

Providers determined to be eligible receive an Incentive payment for that year. Providers have to re-attest each subsequent year to the appropriate MU criteria for each year's continued participation in the Delaware EHR Incentive Program prior to receipt of an Incentive payment. MAPIR processes have been configured to monitor state payments to ensure that a provider is only paid one time for each eligible year. Providers must maintain documentation supporting their demonstration of MU for seven years.

## 4..11 Provider TIN Assignment

DMMA currently requires that all providers submit a valid TIN as a condition of Medicaid provider enrollment. Each EP or EH is enrolled as a Medicaid provider and therefore meets the requirement to supply a TIN.

The R&A System includes not only the EPs Personal TIN, but also the Payee TIN. DMMA assigns the payment at the state level, as the R&A System has no way to validate the payee TIN/EP TIN combination. The Delaware EHR Incentive Payment R&A function lists the valid individual and group NPIs, names, State provider IDs and TINs associated with the EP who is registering. Providers may elect to have their incentives paid to their NPI/TIN or another NPI/TIN, as long as the payee is a DMES enrolled provider. In support of this, the DMES EHR Incentive Payments financial transactions use the pay-to information on the EHR Incentive payment request to determine the payment recipient. If the pay-to provider is not a billing provider, the provider must enroll in DMAP to be considered for Delaware EHR Incentive Program participation.

The TIN is used to identify the providers on IRS Form 1099 and allow IRS reporting based on the appropriate TIN where providers have received an EHR Incentive payment from DMMA. Current business and system processes support the use of TIN to identify provider payments.

## 4..12 Provider Payment Calculations

DMMA ensures certain conditions have been met prior to making Incentive payments to EPs. These conditions include:

- Provider has adopted, implemented, upgraded, or is a meaningful user of certified EHR technology
- Provider does not appear on the CMS, Office of the Inspector General (OIG), or Delaware sanctions list
- Provider has not already received a payment from another state or Delaware in the current program year

Each EP may receive a maximum total incentive of $63,750 over six payment years. The first payment year's maximum amount is $21,250, and payment years two through six are capped at $8,500 each year. To receive the first year's Incentive payment, providers must demonstrate they are adopting or implementing certified EHR technology or upgrading to certified EHR technology. In order to continue receiving incentives in payment years two through six, providers must achieve and maintain the MU criteria described in the final regulations.

MAPIR provides the mechanism that allows Delaware to accurately enroll providers, calculate incentive payments, and monitor providers participating in the Delaware EHR Incentive Program. The system has been designed to interface with DMES and create transactions for payment from DMES. The payment information (e.g., check date, payment date) is stored in MAPIR. Tracking of subsequent payment years and MU is being tracked through MAPIR.

The basic flow for internal processing of EP Incentive payments in MAPIR (see Figure 8 in Section 4.6.3) is explained below:

1. MAPIR batch scheduler initiates the batch process.
2. Batch process extracts all the provider applications that are in a Submitted status and do not yet have a calculated incentive payment amount.
3. Batch process pulls all relevant data from the application to calculate the incentive payment including payment year.
4. Batch process performs the incentive payment calculation.
5. Batch process stores the calculated incentive payment amount within MAPIR.
6. Status of application is not updated and remains as Submitted.

DMMA began making incentive payments in November 2011 to providers that registered for the program and demonstrated that they adopted, implemented, or upgraded to certified EHR technology.

### 4..12.1 EP Payment Calculation

DMMA makes payments up to 85 percent of a net allowable cost not to exceed a maximum in the first year of $21,250 and a maximum of $8,500 in subsequent years. CMS determined the total cost to acquire certified EHR technology and implementation support for the purposes of this program to be $54,000. Through the Medicare and Medicaid Extenders Act of 2010, CMS has determined that average contributions from outside sources to be $29,000. Therefore the net average allowable cost for all EPs is $25,000 ($54,000 - $29,000) in the first year. The payment is 85 percent of this average allowable cost, $21,250 in year 1. In subsequent years, after contributions, the net average allowable cost is $10,000. The subsequent year payment of 85 percent of this average allowable cost is $8,500.

**First Year:** -$\$21{,}250 \geq 0.85(Average\ Allowable\ Cost - Payments\ from\ Other\ Sources)$

**Subsequent Years:** -$\$8{,}500 \geq 0.85(Average\ Allowable\ Cost - Payments\ from\ Other\ Sources)$

### 4..12.2 EH Payment Calculation

Delaware decided to pay the aggregate hospital incentive payment amount over a period of three annual payments, contingent on the hospital's annual attestations and registrations for the annual Delaware Medicaid payments.

The data on hospital discharges are identified by the hospital fiscal year that ends during the federal fiscal year (FFY) prior to the hospital fiscal year that serves as the first payment year.

Therefore, if the payment year is 2011, the prior FFY is 2010 or 10/01/2009 – 09/31/2010. The hospital fiscal year that ends during this period would serve as the base year. If the hospital base year is 08/01/2009 – 07/31/2010, the hospital growth rate is determined using hospital fiscal years ending on 07/31/2006, 07/31/2007, 07/31/2008, and 07/31/2010. The four years used to determine the incentive payment would end 07/31/2010, 07/31/2011, 07/31/2012, and 07/31/2013.

For EH to be eligible to start the payment calculation process an EH must:

- Have a CMS Certification Number that has the last four digits in the series *0001-0879 or 1300-1399 or series* 3300-3399.
    - Only for series 0001-0879 or 1300-1399
        - The average length of patient stay of 25 days or fewer;
        - Must meet a 10 percent Medicaid patient volume threshold

The Delaware EHR Incentive Program hospital aggregate incentive amount calculation uses the equation outlined in the proposed rule, as follows:

$$\boldsymbol{EH\ Payment = Overall\ EHR\ Amount \times Medicaid\ Share}$$

Where:

- ***Overall EHR Amount*** = {Sum over 4 year of [(Base Amount plus Discharge Related Amount Applicable for Each Year) times Transition Factor Applicable for Each Year]}
- ***Medicaid Share*** = {(Medicaid inpatient-bed-days + Medicaid managed care inpatient-bed-days) divided by [(total inpatient-bed days) times (estimated total charges minus charity care charges) divided by (estimated total charges)]}

The diagrams below outline the steps and organization for calculating payments.

Step 1 includes the total discharges reported by the EH on the Hospital Cost Report worksheet S-3, Part I, Line 12, column 15 – Total Discharges for each of the respective years.

**Table 11: EH Incentive Calculation - Step 1**

*Step 1* *Calculate the average annual growth rate for the last 3 years of available data using previous hospital cost reports.*

| | Prior Year | Current Year | Increase/ Decrease | Growth Rate | Data Source | Line Number(s) |
|---|---|---|---|---|---|---|
| Fiscal Year 2006 | N/A | 16,000 | N/A | N/A | | |
| Fiscal Year 2007 | 16,000 | 16,500 | 500 | 3.13% | | |
| Fiscal Year 2008 | 16,500 | 17,000 | 500 | 3.03% | | |
| Fiscal Year 2009 | 17,000 | 17,500 | 500 | 2.94% | | |
| | Total Increase/(Decrease) | | | 9.10% | | |
| | Average 3 year Growth Rate | | | 3.03% | | |

Step 2 is input from the Hospital Cost Report worksheet S-3, Part I, Line 12, column 15 – Total Discharges for Fiscal Year 2010.

**Table 12: EH Incentive Calculation - Step 2**

| Step 2 | Calculate the discharge related amount using the annual growth rate to adjust discharges for years 2 - 4. | | | | | Data Source | Line Number(s) |
|---|---|---|---|---|---|---|---|
| | Total Discharges | Fiscal Year | 2010 | | 22,000 | | |
| | | Per Discharge Amount | Total Discharges | Disallowed Discharges | Allowable Discharges | Amount | |
| | Year 1 | $ 200 | 22,000 | 1,149 | 20,851 | $4,170,200 | |
| | Year 2 | $ 200 | 22,667 | 1,149 | 21,518 | $4,303,615 | |
| | Year 3 | $ 200 | 23,354 | 1,149 | 21,851 | $4,370,200 | |
| | Year 4 | $ 200 | 24,063 | 1,149 | 21,851 | $4,370,200 | |
| | | | Total Discharge Related Amount | | | $17,214,215 | |

Step 3 calculated the Aggregate EHR amount over a 4 year period using the base EHR amount plus the amount attributable to the EH's discharges determined in Step 2.

**Table 13: EH Incentive Calculation - Step 3**

| Step 3 | Calculate the Initial Amount for 4 Years | Year 1 | Year 2 | Year 3 | Year 4 |
|---|---|---|---|---|---|
| | Base Amount | $2,000,000 | $2,000,000 | $2,000,000 | $2,000,000 |
| | Discharge Related Amount | $4,170,200 | $4,303,615 | $4,370,200 | $4,370,200 |
| | Aggregate EHR Amount | $6,170,200 | $6,303,615 | $6,370,200 | $6,370,200 |

Step 4 applies a transition factor to each year of the Aggregate EHR amount calculated above in Step 3. The transition factor starts with 1 and decreases with each respective year by one quarter till year 4.

**Table 14: EH Incentive Calculation - Step 4**

| Step 4 | Apply Transition Factor | Year 1 | Year 2 | Year 3 | Year 4 |
|---|---|---|---|---|---|
| | Transition Factor | 1.00 | 0.75 | 0.50 | 0.25 |
| | Transition Factor | $6,170,200 | $4,727,711 | $3,185,100 | $1,592,550 |

Step 5 then sums the resulting yearly Transition Factor calculations performed in Step 4.

**Table 15: EH Incentive Calculation - Step 5**

| Step 5 | Calculate Overall EHR Amount for 4 Years (total of years 1 - 4 in Step 4) | $15,675,561 |
|---|---|---|

Step 6 uses information contained in the Hospital Cost Report worksheet C and S to determine the Medicaid Share as depicted below.

**Table 16: EH Incentive Calculation - Step 6**

| Step 6 | *Calculate Medicaid Share from Hospital Cost Report data* | | | | |
|---|---|---|---|---|---|
| | (estimated Medicaid inpatient-bed-days + estimated Medicaid HMO inpatient-bed-days) / (est. Medicaid IP-bed-days x ((est. total charges - est. charity care charges) / est. total charges)) | | | | |
| | | | | Data Source | Line Number(s) |
| | Total Medicaid Inpatient Bed Days | 17,500 | | | |
| | Total Medicaid Managed Care Inpatient Bed Days | 1,350 | | | |
| | Total Medicaid and Managed Care Inpatient Bed Days | | 18,850 | | |
| | Total Hospital Charges | 5,000,000 | | | |
| | Total Charity/uncompensated care charges | (1,000,000) | | | |
| | Total Hospital Charges - Charity charges | 4,000,000 | | | |
| | Divided by Total Hospital Charges | 5,000,000 | | | |
| | Non-charity percentage | 80.00% | | | |
| | Total Hospital Inpatient Bed Days | 50,000 | | | |
| | Total Hospital Inpatient Bed Days excluding charity | | 40,000 | | |
| | **Medicaid Share** | | **47.13%** | | |

Step 7 multiplies the Medicaid Share in Step 6 to the Overall EHR amount derived in Step 5 to arrive at the Medicaid Aggregate EHR Incentive Amount for the EH.

**Table 17: EH Incentive Calculation - Step 7**

| Step 7 | *Calculate Medicaid Aggregate EHR Incentive Amount* | |
|---|---|---|
| | Overall Amount for 4 years | $15,675,561 |
| | Medicaid Share | 47.13% |
| | **Medicaid Aggregate EHR Incentive Amount** | **$7,387,108.25** |

Step 8, the final step, determines the hospital's final payments that are disbursed by the percentages defined in the Rule. For the first year, 50 percent of the aggregate amount was paid to the EH. In the second year, if all conditions for payment are met, 40 percent of the aggregate amount is paid to the EH. In the third year, if all conditions for payment are met, 10 percent of the aggregate amount will be paid to the EH.

Additional criteria is used to verify that in any given payment year no annual Medicaid incentive payment to a hospital may exceed 50% of the hospitals aggregate incentive payment. Likewise, over a two-year period, no Medicaid payment to a hospital may exceed 90% of the aggregate incentive payment.

Hospitals choosing to change from the state originating the previous EHR incentive payment(s) may do so provided that both Delaware EHR Incentive Payment Program and the selected transfer state have consulted with and have received the approval from CMS.

### 4..12.3 Payments to Eligible Providers through Managed Care Plans

This requirement does not apply because DMMA pays the managed care providers directly, the same as for providers not in managed care. Managed care providers need to enroll in DMAP in order to participate in the Delaware EHR Incentive Program.

### 4..12.4 Provider NPI

DMMA currently requires that all providers submit a valid NPI as a condition of Medicaid provider enrollment. Each EP or EH must be enrolled as a Delaware Medicaid provider and therefore, without any change in process or system modification, meets the requirement to receive an NPI. DMMA performs a search of the NPPES to validate NPIs during the enrollment process.

## 4..13 Role of Contractors in the EHR Incentive Program Implementation

DMMA leverages the services of a contractor to provide FA services. DXC, acting as the State's FA, operates DMES and many of the supporting business processes and activities needed to manage the Medicaid program. DXC operates and maintains DMES and will be responsible for the installation and customization of the MAPIR. DXC also provides claims processing and all mandatory DMES functions. In addition, DHSS contracts with DXC for pharmacy consultant services, a client pharmacy call center, Provider Relations support, PDL and drug supplemental rebates, DPAP processing, TPL verification and lead processing, DUR, Health Benefit Management services, Health Care Program Premium processing, and ad-hoc query environment management.

DXC supports the Delaware EHR Incentive Program MAPIR application, and the verification and payment processes. DXC provides Provider Relations staff, business analysts, and system programmers to support MAPIR and the EHR Incentive Program operations.

DMMA is responsible for the overall oversight and administration of the Delaware EHR Incentive Program operations; DXC participates in the development of any additional system and process solutions needed to support the Program as requested by DMMA. DMMA develops or updates procedure manuals as necessary to guide the actions of DXC for delegated tasks related to the Delaware EHR Incentive Program.

## 4..14 Reporting Requirements

Enhancements have been made to MMIS and MAPIR is updated with each new version to ensure all reporting requirements and modifications are made to meet the needs of the Delaware EHR Incentive Program. DMMA updated the MAR reporting process, the current financial and expenditure reports, and administrative reports to correctly capture the information required from this program. A new category of service (COS) for state and federal reporting was created for the program. The MSIS file was modified to accommodate information on the Delaware EHR Incentive Program. An additional line item payment information was incorporated into the monthly DMES processes for the CMS-64 reporting change. Custom MAPIR reporting was added to properly validate appropriate calculations and program tracking. A query has been developed against the MAPIR Administrative data to complete the CMS

Annual Report. A Master Report that summarizes annual program and payment year data by provider NPI was developed as part of MAPIR version 5.0 program updates and was revised in subsequent MAPIR versions.

### 4..15 Coordination with Medicare to Prevent Duplicate Payments

DMMA uses the R&A System to make sure that EPs are not referred to Delaware Medicaid if they have already received a Medicare payment. Additionally, the R&A System limits EPs to applying for either the Medicaid or the Medicare incentive each year. Prior to payment of the incentive, the MAPIR system reports the request for payment to the R&A System based on unique provider NPI and TIN to ensure that Delaware EPs do not collect EHR payments from both Medicare and Medicaid in the same year. Only upon the R&A System clearance that no other payments have been issued is the Delaware payment released to the financial sub-systems for issuance.

### 4..16 PI Monitoring

DMMA ensures that Medicaid funds are used effectively and in compliance with federal and state regulations. Existing processes have been expanded to include the requirements for the Delaware EHR Incentive Program. The PIP Team is responsible for the prepayment monitoring of eligibility and attestations. PI intervenes upon findings of fraud in post payment audits and investigates the situation and coordinates with the HIT Coordinator and PIP Team to set payment recoupment and correction strategies for the provider. Audit findings are provided to the Medicaid Fraud Control Unit (MFCU) in the Attorney General's (AG) office for assistance and further action against the provider.

In accordance with CMS requirements, the DMES weekly financial cycle must allow incentive payments to be paid in full regardless of any outstanding amounts the provider may owe. Because incentive payments are funded 100 percent by CMS, all incentive payment activity must be tracked separately in the MMIS financial system and weekly financial reports. New financial reports and other ad hoc reports were developed in On Demand in DMES for DMMA use to track provider incentive payment activity. Incentive payment activity is included on the provider's electronic RA/HIPAA 835 transaction, the paper RA, and their annual 1099. Once payments have been processed in the weekly financial cycle, the MMIS creates a Remittance Voucher Detail file for MAPIR to confirm that payment was made. A new MMIS batch process was developed to extract financial information for incentive payments that were processed in the weekly cycle. This file was structured into the MAPIR-specified format, and it is copied into the MAPIR file system. MAPIR receives this file at a scheduled time and uses it to update the MAPIR database.

DXC conducts periodic non-clinical, remote audits of EPs and EHs to ensure ongoing compliance with the incentive payment program requirements. Audits will include all 7 Delaware-based hospitals, and 30 EPs bi-annually. Audits target providers close to the 30 percent patient volume threshold. With hospitals in particular, DHSS and DXC have established outlier criteria for the auditing process.

More detail on the Audit process can be found in Section 5 of this document and in Appendix C, the Audit Strategy for the Delaware EHR Incentive Payment Program.

### 4..16.1 Incentive Payment Recoupment

The EHR Incentive Program rule requires recoupment of inappropriate payments made under the program; in addition, no funds owing outside the EHR Incentive Program can be recovered/deducted from incentive program payments. The DMES will recoup inappropriate payments or overpayments of incentive funds from future incentive payments. However, because the payments are annual, a manual AR can be entered to receive repayment outside the funding source to allow recoupment against claim payments if necessary. MAPIR is used to store and track records of incentive payments for all participating providers. T h e PIP Team regularly monitors payments to ensure over/inappropriate payments are not made. Once an over/inappropriate payment is identified the PIP Team determines the amount that must be returned and then initiates the payment recoupment process by notifying the provider. DMMA will request that providers submit recoupment payments by check; if a provider fails to submit the payment within 30 calendar days of the notice to return the funds, DMMA will generate an AR to offset payment against future program payments. Federal law requires DMMA to return over/inappropriate payments within 60 days ofidentification.

DMMA already has a system in place for tracking recoupment of over/inappropriate payments from providers. The system has been expanded to allow for tracking and reporting specific to EHR Incentive payments and these are monitored on an ongoing basis. DMMA reviews monthly reports to determine the status of recoupment of overpayments.

### 4..16.2 Fraud and Abuse Prevention

The PIP Team and the DMMA SUR/PI unit support the investigation of potential misuse by providers and clients of the Medicaid Program and other programs administered by DMMA.

The PIP Team analyzes the data and reports those participants whose patterns deviate from established norms. Abnormal findings are first reported to SUR/PI for further review and investigation. At the point they believe fraud exists, a referral is made to the MFCU in the AG's office.

The responsibility of prosecution of all fraud cases lies within MFCU. PI resolution functions, including litigation support and negotiating settlements or payment plans, is the responsibility of the AG. The MFCU also accesses DMMA claims data to support its investigations. Per the Memorandum of Understanding (MOU) with the MFCU, all audits with an identified overpayment of $500 or more or any audit where potential fraud is identified regardless of the amount of overpayment are referred to the MFCU.

The provider may be suspended as part of the process; if an enrolled provider was complicit in fraud, DMMA may need to recoup Medicaid funds in the process. Depending on the parties involved, the DMMA may also contact appropriate licensing boards and other agencies.

### 4..16.3 Provider Appeals

An eligible Medicaid provider can appeal if it determines it has been denied an incentive payment or has received an incorrect payment amount. In collaboration with DHSS, DXC developed an appeals procedure related to provider eligibility, incentive payment amount, and determination of MU. The appeal process in MAPIR for denial of payment amount or of eligibility for the program is documented in Figure 7 in Section 4.8.2.

An eligible Medicaid provider may appeal any of the following issues:

- Denial of Incentive payment
- Incentive payment amount
- Provider eligibility determinations
- Demonstration of adopting, implementing, and upgrading
- MU eligibility

Appeals related to the EHR Incentive Program are initiated through MAPIR, and follow a similar process as currently used for Medicaid participation appeals. The appeal goes to the PIP Team which reviews the complaint, does research to investigate, and issues findings and recommendations for disposition. These recommendations then go to the HIT Coordinator to route appropriately through DMMA for final determination. After DMMA has made an appeal determination, the results will be tracked and reported back to the EP or EH.

If the result is unsatisfactory to the provider, the DMAP appeal procedures must be followed in accordance with Appendix A of the Delaware Provider Policy Manual, beginning with section #5, Deputy Director. For the first appeal denial, the provider can elect to utilize an arbitration process to try to resolve the issue. If the provider is again denied, they can then pursue a formal appeal to the DMMA Deputy Director for final determination. Email alerts will be used throughout the appeal process to notify the provider when an appeal has been filed and adjudicated. Adjustments to payments as a result of an appeal will be allocated to the applicable payment year.

A detailed appeals procedure related to provider eligibility, incentive payment amount, and determination of MU has been developed and is part of the Appendix C, Audit Strategy.

## 4..17 Coordination with the Regional Extension Center

Currently, QID is the REC for the State of Delaware. QID has assisted over 1500 Delaware Medicaid/Medicare providers with the following types of direct, individualized, and onsite technical assistance:

- Selecting a certified EHR product that offers best value for the provider's needs
- Achieving effective implementation of a certified EHR product

- Enhancing clinical and administrative workflows to optimally leverage an EHR system's potential to improve quality and value of care, including patient experience as well as outcome of care
- Observing and complying with applicable legal, regulatory, professional, and ethical requirements to protect the integrity, privacy, and security of patients' health information
- Achieving Meaningful Use.
- Regularly scheduled meetings between the REC and the DMMA began shortly after the REC received funding approval. These meetings have become ad hoc when the REC moved to a fee based consulting model. These organizations coordinate efforts to avoid duplication, maximize the use of local resources, and expand the reach of services to extend to providers who are hesitant about participating in the Delaware EHR Incentive Program or that do not qualify for the Delaware EHR Incentive Program, but are vital to the health services of the community.

The Division used the following criteria in descending order of priority to target their outreach and services to those who are not being served by the REC but would benefit from the REC services:

1. Medicaid providers who are eligible for Incentive payments.
2. Medicaid providers who are not eligible for incentives but play a critical role in the health care ecosystem and whose participation would boost participation among other providers/organizations and expedite critical mass.
3. Medicaid providers who could be eligible for incentives but fail to meet all of the eligibility criteria.
4. Non-Medicaid providers that share an interest in establishing EHR usage in the state.

The DMMA plans to continue to solicit input from the REC through the Delaware EHR Incentive Program. Currently, the REC and the DMMA EHR Incentive Program staff hold meetings as needed to discuss the status of each organization's program and to develop ways to collaborate. As part of their outreach, the REC educates providers and provides assistance with navigating the Delaware EHR Incentive Program. Their assistance helps providers assess their eligibility criteria, review calculations, and develop a strategy towards meeting the program criteria for participation. The REC will remain a significant stakeholder in the Delaware EHR Incentive Program activities.

Currently the REC provides fee-based assistance to Eligible Providers who wish to attest to the EHR Incentive Payment Program. We schedule Ad Hoc phone calls with the REC if we need to discuss specific attestation details.

## 4..18 State Provider Incentive Program Administration

Administration of the Delaware EHR Incentive Program will be the responsibility of DMMA. Under the direction of the Medicaid Director, the Medicaid HIT Steering Committee provides oversight of the program. The skills of the Medicaid FA, the REC, and the DHIN all contribute to the success of this program. The organization of the Delaware EHR Incentive Program and its roles and responsibilities within DMMA is shown in Figure 14.

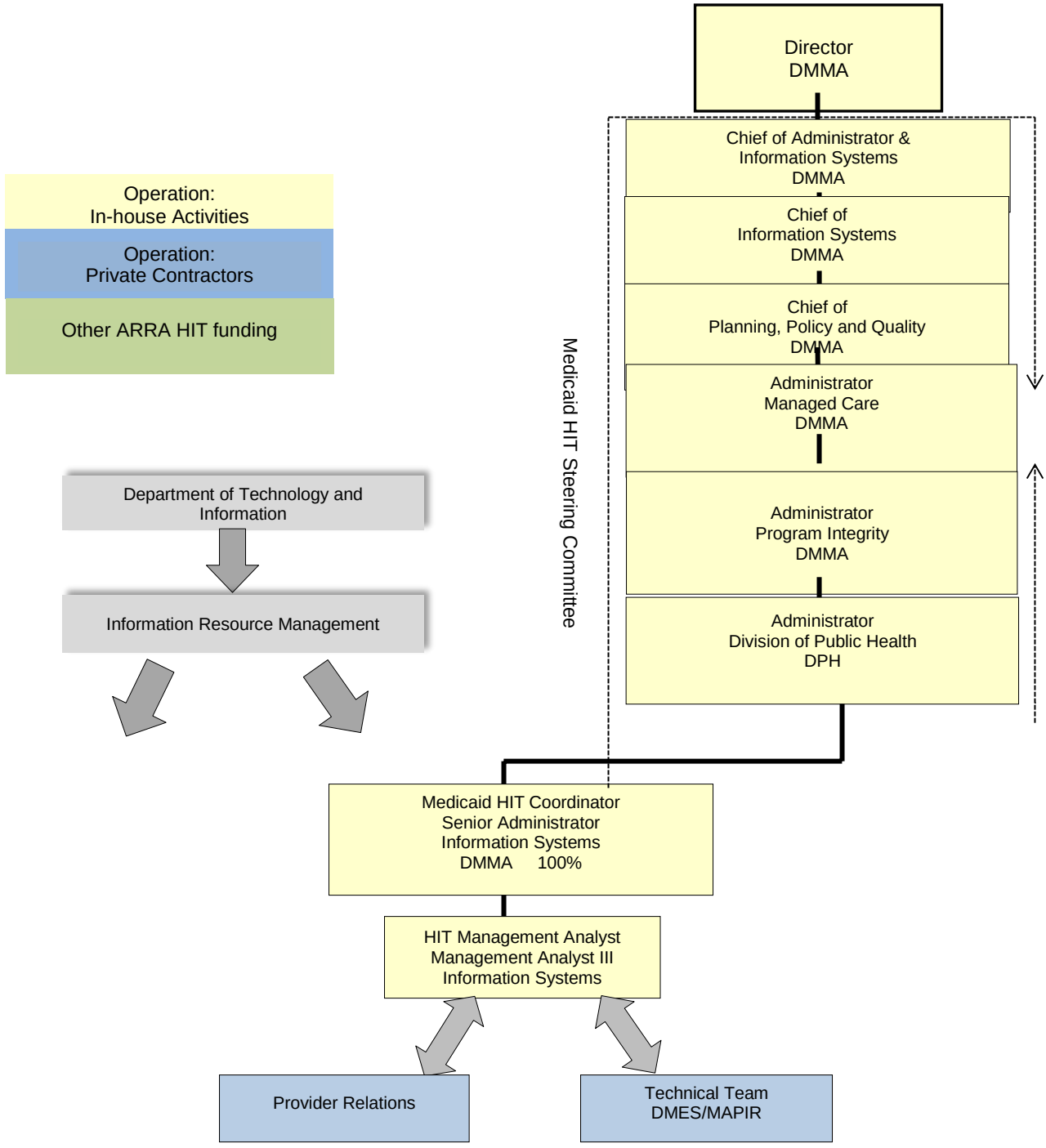



**Figure 14 SMHP Organizational Chart**

The roles and responsibilities of positions identified in the organization chart are further described below.

**Medicaid HIT Steering Committee**

DMMA is responsible for the development and oversight of the Delaware EHR Incentive Program and the development of the SMHP. The Medicaid HIT Steering Committee, under the direction of Stephen Groff, is responsible for the key decisions that need to be made for this program. Steering committee members include DMMA representatives from the Office of the Director, Information Systems, Planning, Policy and Quality, Managed Care Operations, and PI. In addition, the State HIT Coordinator and a representative from the Division of Public Health participate on this committee.

**Information System Unit (ISU)**

The Division's ISU is responsible for working with Medicaid policy and operational staff, state application support staff, federal agencies, contractor staff, including the FA, and any other DHSS staff that rely on Medicaid information systems. The Medicaid HIT coordinator and HIT Management analyst are responsible for oversight of the development and operation of the Delaware EHR Incentive Program. The Medicaid HIT Coordinator integrates technical needs of the state with program needs of this Division and works closely with DHIN, the REC, and the Medicaid FA. The HIT Management Analyst coordinates implementation activities and provides daily support of the program operations conducted by the PIP Team and MAPIR technical team.

**Information Resource Management (IRM)**

The IRM unit is responsible for providing DHSS divisions with direct programming support of automated systems, as well as consulting support and advice on automated systems software and development. IRM consists of an Applications Development, Technology Planning, Base Technology, Telecommunications, and Helpdesk support group.

**DTI**

DTI is a separate cabinet level agency responsible for running the State of Delaware's mainframe computer operations, wide area data network and setting statewide IT policy and standards. DTI as a separate state agency does not fall under the authority of DHSS. However, DTI is responsible for supplying mainframe and Wide Area Network (WAN) systems support to DHSS as well as other state agencies. Additionally, DTI provides 24x7 data center operations support. For this project DTI provides technical consultant services and IT policy and standards. DTI works through IRM on this project to ensure that State IT standards are followed.

**DXC**

As the Medicaid FA for the State, DXC operates and maintains the DMES and is responsible for the installation and customization of the MAPIR. DXC also provides claims processing and all

mandatory DMES functions. In addition, DHSS contracts with DXC for pharmacy consultant services, a client pharmacy call center, provider relations, PDL and drug supplemental rebates, DPAP processing, e-Prescribing (as of 2015, transferred to Medicaid MCOs), TPL verification and lead processing, DUR, Health Benefit Management services, Health Care Program Premium processing, and ad-hoc query environment management. DXC provides Provider Incentive Payment staff, business analysts, and system programmers to support MAPIR and the Delaware EHR Incentive Program operations.

### 4..19 FFP

DMMA authorizes the full amount of each Incentive payment due to the providers through the DMES. DMMA uses existing DMES capabilities to make the Delaware EHR Incentive Program payments. FFP is determined through the standard Manage FFP for Services MITA business process. Delaware ensures that the 100 percent Federal Match is applied and reported appropriately.

### 4..20 Clinical Quality Data

DMMA and other DHSS programs plan to leverage the clinical and MU data made available through the Delaware EHR Incentive Program to meet the federal goals to improve population health, reduce medical errors, improve health outcomes, and empower Medicaid members to participate in their healthcare. The DHIN provides hospital clinical ADT data to the MCOs on a daily basis originating in a pilot project that was developed in September 2013. Security of clinical data will remain a priority and individually identifiable health information will be exchanged only as permitted by HIPAA for purposes of treatment, payment, and health plan operations.

During the first year of the Delaware EHR Incentive Program, the Division only accepted the attestation from providers that performed the tasks of A/I/U. Certified EHR technology was not available until late 2010; all providers must complete the A/I/U tasks first to meaningfully use such technology. During the first year of the program, providers only needed to meet this minimum activity to be eligible for the incentives. Therefore, attesting to MU was unnecessary in this first year.

Based on the Stage One final rule, in year two; providers who have attested to A/I/U in year one must be able to report and attest to the MU measures. DMMA has worked with the MAPIR collaborative to develop the capability to report and attest to the MU Measures for year two of the program. DMMA has developed a set of screens that allow for the entry of numerator and denominator values. The screens validate the entries and calculate the measures. The data is saved within the MAPIR repository and utilized for monitoring and program improvement. MAPIR (enhancement version 5.0) was implemented in June 2013 and addresses changes to the Core Measures and Menu Set for the Stage 1 changes made in the Stage 2 final rule. Attestations for MU Stage 1 and Stage 2 are currently being accepted by the Delaware EHR Incentive Program. Delaware is currently accepting Stage 2 MU applications and could accept Stage 3 in October 2017.

The DHIN would like to collect the appropriate information from the Continuity of Care Document (CCD) in the certified EHR systems and convert it to clinical quality measure. The

DHIN is planning to pursue Qualified Clinical Data Registry certification and therefore compile and report CQMs. It would enhance care coordination and create efficiencies for HEDIS collection for the MCOs. In the future, it would allow for consumer engagement with healthcare and providers and give providers an increased understanding of patient needs and direction for quality improvement activities.

The Delaware General Assembly passed legislation in 2016 authorizing DHIN to stand up a Health Claims Database (HCCD). Reporting to this database will be required for Medicaid and state employee health plans, qualified health plans on the Marketplace, and federal sources such as Medicare. Other health plans may report data on a voluntary basis. Broad use cases contemplated include support for population health initiatives and provider risk sharing. DMMA will explore if the HCCD claims may be used to verify patient volume calculations for the Medicaid EHR Incentive Payment Program. DHIN is in the early stages of planning and implementation. The data collection process began in March 2018. Funding was included in the SFY 2019 budget to support initial development of the HCCD. Freedman Associates provided technical assistance for the project. DMMA will submit a standardized file layout for Medicaid fee-for-service claims and legacy MCO encounter claims for MCO's who are no longer under contract with DMMA. Several commercial payors in addition to the State Employee Health Plans are also in development to submit claims file layouts.

The HCCD could provide DMMA with greater access to a more comprehensive set of data for use in planning and program improvement activities, as well as for analyses that will yield a greater understanding of the needs and outcomes of the Medicaid population and the costs of program care and services. Provider access to data will further enhance care coordination opportunities, eliminate duplication of service, and foster identification of appropriate levels of care. DMMA will be able to more effectively identify serious quality of care issues, gaps in care, member compliance issues, and member behavior trends such as ER utilization.

In 2012, Delaware updated its Quality Management Strategy (QMS) in a comprehensive plan incorporating QA monitoring and ongoing quality improvement (QI) processes to coordinate, assess, and continually improve the delivery of quality care and services to participants in managed care, waivers, and Medicaid and CHIP funded programs. The QMS provides a framework to communicate the State's vision, objectives and monitoring strategies addressing issues of health care cost, quality and timely access. It encompasses an interdisciplinary collaborative approach through partnerships with enrollees, stakeholders, governmental departments and divisions, contractors, MCOs, community groups, and legislators. The DMMA QMS currently incorporates a list of mandatory HEDIS measures to be reported annually by the MCOs. The relevant MU measures will be incorporated into this strategy in the future and should greatly improve the monitoring of access, care delivery, health management, and care expenditures.

## 4..21 State Alternative Methods (if any)

DMMA continues to adhere to the methods outlined in the final rule. The program also follows guidelines provided in the Stage Two Final Rule and has incorporated the changes required by the Flexibility Rule. MAPIR was updated for the Program Year 2015-2017 Modification Rule and will be updated in October 2017 for Program Year 2017 and Stage 3 MU and the Medicare OPPS Rule and Quality Payment Program (QPP).

### 4..21.1 Meaningful Use Criteria

Public agencies are very interested in health information, and DMMA understands that the medical community also wants to see the health of Delaware residents improve. Meeting the MU criteria impacts many stakeholders and in a variety of ways. The benefit of obtaining clinical information must be weighed against the cost of collecting and reporting it. DMMA recognizes that defining MU is not an isolated decision, and prefers participating in a statewide process to collect stakeholder input. This will provide a broad perspective of what is important to all players who will benefit from HIT.

DMMA has determined that to be a meaningful EHR user an EP must have 50 percent or more of their patient encounters during the EHR reporting period at a practice/location or practices/locations equipped with certified EHR technology. An EP who does not conduct 50 percent of their patient encounters in any one practice/location would have to meet the 50 percent threshold through a combination of practices/locations equipped with certified EHR technology.

DHIN objectives and corresponding reporting have evolved accordingly with the release of Stage Two Final Rule and will continue to evolve with the NPRM EHR Requirements for Providers in 2015 through 2017 and into Stage 3 in the Modified Meaningful Use for 2017.

## 4..22 Dependence upon Federal Initiatives

The current federal HIT initiatives, such as the State HIE Cooperative Agreement, the RECs, and broadband initiatives, were designed to set the foundation and provide an environment that would support adoption of EHRs and deployment of state and regional exchanges networks. DMMA is dependent on the success of these initiatives to provide the infrastructure that makes it feasible for individual providers to easily adopt and effectively utilize EHRs and electronic exchange to support and enhance patient care and essential business operations. DMMA is also dependent on the success of other federal initiatives, such as the HRSA and Centers for Disease Control and Prevention (CDC) grants, that support HIT innovation and testing projects that will provide lessons learned, best practices, and specific examples of how EHRs and electronic exchange can benefit both providers and patients.

DMMA is dependent upon CMS for the review and approval of this SMHP as well as the IAPD. DMMA also relies on CMS to maintain the R&A System to provide operational support for provider participation in the program. DMMA relies on CMS educational and technical support to assist states to understand and achieve all MU stages.

DMMA is dependent upon CMS and the ONC for the determining the future MU criteria. DMMA is dependent upon ONC for the certification of EHR systems so that Delaware Medicaid providers can A/I/U to appropriate certified EHR systems and attest to Stage 2 and Stage 3 MU through certified EHR systems.

# 5 STATE PROGRAM AUDIT STRATEGY

DMMA uses a combination of existing and new auditing processes to track and monitor appropriate participation in the Delaware EHR Incentive Program. Appendix C, Audit Strategy and Protocol, is attached to the SMHP and contains details about the EHR Incentive Payment audit process and procedures.

## 5..1 State Audit Process

The DMMA Program Integrity Unit (PIU) is primarily responsible for the detection and prevention of fraud, waste and abuse. Upon positive findings of fraud, the case is referred to MFCU, which then investigates the case. The provider is still able to submit claims, unless the offense is egregious and a decision is made that an administrative action of suspending claims should be imposed. Providers are not restricted in what they can do unless an administrative action is imposed.

The Program Integrity Unit monitors the utilization of Medicaid services to detect, investigate, and take action on findings of fraud, waste, and/or abuse. The Program Integrity Unit fulfills 42 CFR 455.1, which requires that states have a program in place for the identification, investigation, and referral of suspected provider and recipient fraud and abuse.

The Program Integrity Unit seeks to accomplish several outcomes including receipt and investigation of referrals from internal and external sources, reviews and audits for Medicaid providers and recipients, collection of overpayments, and cooperation with the MFCU and Audit and Recovery Management Services (ARMS).

The Program Integrity Unit also provides the following services:

- Operates a fraud and abuse hotline that allows members of the community to report suspected fraud, waste, or abuse
- Performs data mining as well as utilizes the MMIS SUR subsystem to develop profiles that identify aberrant providers and recipients so that investigations and audits can be performed
- Takes proactive measures to reduce fraud, waste, and abuse in the Medicaid program. These proactive measures are ongoing and mainly focus on provider education and policy recommendations and cooperation with other units, divisions and agencies. The PIU will provide oversight of the audits within Delaware EHR Incentive Program. The unit will process fraud findings and ensure corrective action is taken.

## 5..2 Incentive Program Audit Process

The PIP Team, in conjunction with PIU, is responsible for auditing and verification of information submitted for the Delaware EHR Incentive Program. Beyond editing data for acceptableness during the application process as described in section 4, all data will be validated against actual DMES data on the provider and the provider's claims. If a discrepancy is identified, the final approver can deny the application or request provider clarification. Once the application is approved, an R&A System validation verifies that the provider has not already received an incentive payment through another state, or by Medicare in the case of EPs. The payment is

then released to the financial process within the MMIS. The payment to be issued is checked automatically using the existing payment process to ensure that a duplicate payment has not been made. A list of the payments to be sent is provided daily for a final inspection and approval by the PIP Team.

The PIP Team conducts periodic non-clinical, remote audits of providers to ensure ongoing compliance with the Delaware EHR Incentive Program payment requirements. Audits will 60 EPs every 12 months. An audit of all 7 hospitals occurred by December 2013 and in addition the OIG completed a review of payments to hospitals. This resulted in one overpayment and one underpayment according to the OIG's hospital incentive payment calculations. We adjusted the two hospital's payments accordingly.

Audits specifically target providers that meet certain criteria. Providers that meet these trigger criteria are reviewed first. If 60 triggered audits are not identified, providers will be randomly selected from each provider type category until the target quantity of audits is complete.

Below are examples of criteria that are reviewed for the Delaware EHR Incentive Program verification and audit process:

- Provider Eligibility
    - Provider is an enrolled and participating Delaware Medicaid provider
    - Provider meets the EHR Incentive Program provider definition
    - Provider is not participating in another state or the Medicare EHR Incentive Program
    - Provider is licensed and not sanctioned
- Thresholds
    - Provider meets hospital-based provider definition
    - Provider meets Medicaid and/or needy individual patient volume
    - Provider meets practices predominantly threshold if at an FQHC/RHC
- The Flexibility Rule – effective for Program Year 2014 only

  Effective October 1, 2014, the Flexibility Rule granted flexibility to providers participating in Program Year 2014 who were unable to fully implement a 2014 Edition CEHRT for an EHR reporting period on 2014 due to delays in 2014 Edition CEHRT availability. The delays must have been attributable to:
    - Issues related to software development, certification, implementation, testing, or release of the product.
    - Inability to meet 10 percent on Stage 2 Summary of Care Measure – Can attest to Stage 1 2014.
    - Delays in Product Certificaiton.
    - Delays due to volume of providers requiring simultaneous software upgrade.

- Software had functionality problems, required updates or patches, required additional components.
- Providers who were only able to implement 2014 Edition CEHRT for part of a reporting period would be permitted to use the CEHRT options in this rule.

The Flexibility Rule did not allow for delays attributable to:

- Provider waiting too long to purchase software.
- Lack of staff or resources.
- Financial issues – cost of implementing, upgrading, installing, testing, or other similar financial issues.
- Issues related to MU objectives and measures (limited exceptions).
- Could not meet one or more measure for reasons unrelated to implementation challenges.
- Staff changes and turnover.
- Provider inaction or delay.
- If over 50 percent of the EP's patient encounters during the EHR reporting period occurred at locations equipped with 2014 Edition CEHRT which has been fully implemented, the EP would not be eligible to use the flexibility options in this final rule and should; therefore, limit their denominators to only those patient encounters in locations equipped with fully implemented 2014 Edition CEHRT.
- Participation in the EHR Incentive Program for 2014 and subsequent years was not altered under this rule.

- MU
  - Provider meets requirements for adoption, implementation, or upgrade for year one
  - Provider meets Stage 1 MU criteria in year two
  - Provider meets Stage 1 MU criteria established in Stage 2 Final Rule
  - Provider meets Stage 2 MU criteria in 2014
  - Provider meets Stage 3 MU criteria in 2017
  - In subsequent years, provider meets the criteria established for the appropriate stage of MU
- Payment Reviews
  - Provider has not received duplicate payments
  - If required, the State has requested payment recoupment and monitored provider for compliance

Using a standardized audit program, the PIP Team in cooperation with PI will review a checklist of criteria that must be met.

Sources that auditors will use to validate the checklist may consist of the following:

- Receipts for purchase of a certified system/system component; either software or hardware
- CMS Certified HIT Product List (CHPL) Repository
- Training program sign-in sheets
- HIE audit history of connectivity and use
- Documentation of volume from neighboring states
- Medicare cost reports
- Provider EMR reporting of volumes and activity
- R&A System reporting
- State licensing and sanction data and files
- DMES provider and claims data
- State hospital discharge data
- Patient rosters
- Billing records from provider
- Provider EHR A/I/U progress reports
- Provider MU attestation documentation

PIP Team will conduct initial reviews of the selected applications of participating providers. Potential fraud will be reported to PIU. PIU will coordinate recoupment of incentives with the PIP Team and the Financial Unit. Potential fraud is reported to MFCU for further investigation and action.

### 5..2.1 Audit Approach

The Delaware program employs automated and manual validation and verification processes to ensure pre-payment correctness (See Section 4). In the MAPIR system, each step of the prepayment application process is verified independently to ensure each criterion was appropriately met. Additionally, pre-payment review will be conducted to assure that provider data is accurate wherever possible. Finally, a post payment audit will be utilized for approximately sixty of the EPs and all EHs based on estimated provider participation.

Audits will be conducted post payment for all things attested, including, but not limited to, financial paperwork, the technology components, percentage of Medicaid population visits. All reviews will ensure that no duplication of payment occurred within the EHR Incentive Program.

Providers will be identified for audit based both on targeted selection and a proportional random selection. Targeted audits are identified using the audit risk assessment criteria.

Potential data sources for audits are as follows:

- Eligibility criteria (provider type, non-hospital based licensure/sanctions)--MMIS provider files, claims, state licensing data, state sanctions file, documentation from provider
- Patient volume—claims database, state hospital discharge data
- Needy individual volume—patient rosters, billing records from provider
- Certified EHR criteria—CMS database plus proof of A/I/U
- A/I/U—proof of purchase, progress reports, implementation costs
- MU—review claims and patient rosters
- Payment year—internal MAPIR and MMIS checks, R&A System
- Attestations—same as in all bullets above

DMMA HIT coordinator developed a detailed audit strategy and protocol, attached as Appendix C, with input from DXC, designed to meet the specific objectives of the audit function for the Delaware EHR Incentive Program. The protocol addresses the entire audit process. Audit findings and conclusions are reported to DMMA PI in the same fashion as other current investigative findings are submitted. Audits will follow existing DMMA internal audit policies for planning, audit supervision, development for audit findings, and work papers.

## 5..3 Provider Payment Monitoring, Verification, and Auditing

### 5..3.1 Provider Payment Monitoring

MAPIR will provide application data for the PIP Team to review in order to identify areas of high risk for payment errors (e.g., patient volume levels; provider participation as a pediatrician, since this category has a lower volume threshold).

In order to ensure that no amounts higher than 100 percent of FFP are claimed for reimbursement, payments to Delaware EHR Incentive Program EPs are reported on a separate line on the CMS-64 report. This report is reviewed for accuracy and deficiencies. Payments are made directly to an EP, an EH, or to an employer or facility to which the provider has assigned payment. The State has no current plans to designate any entities for promoting the adoption of certified EHR technology.

System controls have been implemented and tested in the DMES Financial subsystem to ensure appropriate payments and reporting. The MAPIR system interrogates the R&A System based on unique provider NPI and TIN prior to completing the payment process to ensure that Delaware EPs or EHs do not collect EHR payments from multiple states. This process also ensures that EPs have not previously received a Medicare payment.

Providers are required to attest to the year of their participation and that they are not participating in the Medicare Incentive Program (for EPs) or any other State Provider Incentive Program. Communications with the CMS R&A System are used to validate this information prior to making an incentive payment. Successful payments are reported to the R&A System to prevent duplicate payments from another state or from Medicare if applicable.

Provider participation in the Delaware EHR Incentive Program is tracked in the MAPIR and DMES. The provider's status relative to program eligibility is assessed with each annual payment request. The eligibility determination includes the interrogation of the R&A System to assess previous payments based on unique provider NPI and TIN. MAPIR stores the year in which payments are requested, and the Delaware EHR Incentive Program requirements relevant to the year of the request. Each EP is limited to a maximum of six payments. New provider Delaware EHR Incentive Program participation requests will not be allowed after March 31, 2017.

As part of DMMA's CMS report, DMMA submits program participation data to CMS including data for the number, type and practice location(s) of providers that qualified for an incentive payment on the basis of having adopted, implemented, or upgraded to certified EHR technology, or that qualified for an incentive payment on the basis of having meaningfully used such technology, as well as aggregate de-identified data on MU for participating providers.

### 5..3.2 Methods to Identify Improper Payments, Overpayments, Fraud, and Abuse

To avoid making improper or duplicate payments, the R&A System is checked prior to authorizing a payment. An audit trail is maintained containing the date/time of R&A System files sent and received. The MAPIR system has been programmed to validate responses during enrollment and stores information for physical validation prior to payment. The PIP Team is responsible for additional up-front reviews of provider eligibility and attestations. Once incentive payments have been disbursed, the PIP Team identifies participating providers for post- payment audits. Post-payment audits will be conducted by the PIP Team, and the findings reported to PI. PI will intervene when potential fraud is detected and pass the findings to OIG.

If an audit identifies an overpayment or improper payment (one made to an ineligible provider), the amount of the overpayment determined will be recouped from the provider, in accordance with existing DMMA procedures. Overpayments will be tracked through existing DMES processes. Any Delaware EHR Incentive Program funds recouped from providers will be identified on the CMS-64 in accordance with normal reporting procedures as well as through any specific Delaware EHR Incentive Program funding reports. Payments will not be made if in any given payment year MU is not met. Complete procedures for identification and disposition of overpayments and inappropriate payments are found in Appendix C.

Suspected fraud or abuse involving incentive payments can be reported through existing means such as the Medicaid Welfare Fraud Hotline operated by the OIG Division of Audits and Investigations (A&I), or by contacting DMMA directly. Abnormal findings are reported to OIG, which conducts preliminary investigations. If an audit finds indications of fraud, a referral is made to the Delaware AG's Office, MFCU, in accordance with existing DMMA policies and the MOU with the MFCU. Depending on the parties involved, the DMMA may also contact appropriate licensing boards and other agencies.

### 5..3.3 Provider Attestation Monitoring, Verification, and Auditing

When providers request payment under the Delaware EHR Incentive Program, they are asked to attest to a number of factors that must be met before payment is approved. DMMA has defined the attestation criteria for providers applying for an Incentive payment to include each of the program eligibility criteria in the first year including obtaining documentation of sanctions from various licensure boards. For subsequent years, DMMA has developed additional methods of verification as the providers will need to demonstrate their ability to "meaningfully" apply the capabilities of their EHR systems. The attestation is submitted through MAPIR, and follows a process similar to the DMMA eligibility verification process used to review a provider's initial application for the Delaware EHR Incentive Program.

When providers request payment under the Delaware EHR Incentive Program, they are asked to attest to, and DMMA will verify, the following:

1. Overall content and completeness of provider attestation information.
2. Provider eligibility, program, and payment assignment.
3. Providers are not sanctioned, and are properly licensed/qualified providers.
4. EPs are not hospital-based.
5. Patient volume is met.
6. Indicate whether adopting, implementing, or upgrading to certified EHR technology by providers.
7. Indicate participation year.
8. Submit MU of certified EHR technology in the second and succeeding participation years.
9. Supporting documentation is submitted and appropriate (see Section 5.3.9 below for verification of A/I/U).
10. Statement of attestation is made.

Provider attestation information will be reviewed by DMMA to determine eligibility for payment.

Upon approval of a provider's attestation, DMMA generates an email to the provider confirming approval and detailing the next steps in the payment process. Providers receive a denial electronically via the MAPIR with instructions regarding the appeal process if the provider's application/attestation for the Delaware EHR Incentive Program is denied.

### 5..3.4 Verifying Provider Eligibility

All eligibility criteria submitted to apply for or attest to the EHR Incentive Program is subject to verification. The verification process confirms submitted data through access to the following data sources:

- Eligibility criteria (provider type, non-hospital based. licensure/sanctions) - DMES provider files, claims, state licensing data, state sanctions file

- Patient volume—claims database, cost reports for hospitals
- Hospital calculations—may confirm with each hospital in advance
- Needy individual volume—patient rosters, billing records from provider
- Certified EHR criteria—CMS database plus proof of A/I/U
- A/I/U—proof of purchase, progress reports, implementation costs
- MU—review claims and patient rosters
- Payment year—internal checks with MAPIR and MMIS, R&A System
- Attestations— same as in all bullets above

EPs are audited to ensure, for example, that the provider type reported on their application accurately depicts the care being provided. For instance, a reported pediatrician will be audited to ensure he/she is acting like a pediatrician by providing the majority of their Medicaid services to children as documented by their submitted claims.

### 5..3.5 Verifying EP Patient Volume

DMMA through DXC verifies, by review of claims and billing, the validity of the attested patient volume during the reported 90 day period and further, that all numbers attested to during the selected fiscal year (FY) are accurate.

EP patient volume is verified by comparing the Medicaid patient volume reported by the EP with claims data to determine whether the numbers may be inflated or include CHIP beneficiaries. Providers that serve patients in other states should be able to provide proof of their Medicaid patient volume outside of Delaware. DMMA will collaborate with other states to ensure the volumes are correct.

### 5..3.6 Assuring Providers Are Not Hospital-Based

EPs must attest that they are not hospital-based. Professional claims for the reporting period are analyzed, with the provider's NPI in the rendering provider field, to determine the place of service submitted on their claims. Since the definition of "hospital-based" now includes inpatient or ER setting, DMMA uses appropriate codes as a basis for establishing "hospital-based" services. Analysis will be made of professional and institutional claims (and dental claims, for dental providers) to verify where their Medicaid member services are rendered.

The PIP verifies that EPs are not hospital based by substantiating that less than 90 percent of patient encounters are at the ER or in an inpatient setting. This process will be completed by reviewing claims and billing for place of service.

EPs who can demonstrate that the EP funds the acquisition, implementation, and maintenance of certified EHR technology, including supporting hardware and any interfaces necessary to

meet meaningful use without reimbursement from an eligible hospital or CAH and uses such certified EHR technology in the inpatient or emergency department of a hospital (instead of using the hospitals CEHRT) are eligible for incentive payments.

### 5..3.7 Verifying ACH Patient Volume

EH Hospital Cost Report Data will be scrutinized to determine if the actual numbers reported can be supported. The PIP Team may require the EH to produce supporting documentation in order to verify the validity of the cost report and the information submitted to receive the incentive payment. This may include, but is not limited to, bank statements, Medicare documents, inpatient and outpatient bed data, discharges, observation days, neonatal care, ER losses, indigent care figures, cost to charge ratios, ancillary services, supplies and certified consolidated financial statements.

Through review of claims, billing, and other documentation, the PIP Team verifies the validity of the attested patient volume during the ACH reported 90 day period.

### 5..3.8 Ensure Providers are Licensed, Not Sanctioned

DMMA's existing process for provider licensure and sanctions verification will assure that only valid providers can apply for the EHR incentive program. All providers at the time of enrollment, revalidation and annual disclosure into Delaware Medicaid are processed through LexisNexis. The LexisNexis real-time interfacing service will verify the following at the time of application submission:

NPI

Social Security Death Master File

Tax Identification

Name

Professional Licensure Boards

OIG/SAM

CMS PECOS site is checked manually.

Once a month, the Provider Licensure Board interfaces with the MMIS to update license information and status for Delaware Medicaid providers. Annually, providers are required to logon and disclose criminal and licensure issues for DMMA review. Failure to do so results in provider termination. Provider portal activity is only allowed for active providers. Therefore, any provider that is not in an active status will not be able to access MAPIR and complete an application for the EHR incentive program.

### 5..3.9 Verification of A/I/U, MU, and Certified EHR Technology

Both the eligibility and attestation processes require verification of EHR adoption status by hospitals and providers. A/I/U is defined by the final rule as acquiring or upgrading a system. Implementation is defined by the final rule as having installed or commenced utilization of certified EHR technology. Training, according to the final rule, is considered an implementation activity.

Delaware providers must provide the CMS EHR Certification ID, which is unique to a product or a combination of products, not the provider.

MAPIR validates the EHR Certification ID number for A/I/U prior to approving payment. Providers will be required to provide supporting documentation such as invoices, licensing or services agreements, or payment receipts to prove A/I/U of certified EHR technology.

MAPIR validates EHR Certification ID for MU and will verify certification of provider EHR for 2014 Stage 2 MU. Providers attesting to MU (Stage 1 or Stage 2) will attest in MAPIR. MAPIR will determine the CEHRT Edition and present corresponding options for attestation consistent with the Flexibility Rule for Program Year 2014 and Program Year 2015 – 2017.

Medicaid performs desk audits and contacts the provider contacts directly to request supporting documentation.

# 6 HIT ROADMAP POST EHR INCENTIVE IMPLEMENTATION

The purpose of the HIT Implementation Roadmap is to identify and describe the sequencing of planned activities and associated milestone dates to implement the Delaware EHR Incentive Program. DMMA took an incremental approach to the implementation of the Delaware EHR Incentive Program in 2011, and started by focusing on core incentive processes and A/I/U for year one. Provider outreach and communication, provider registration, provider attestation and verification of eligibility, provider payments, and post payment audits were central to implementation of the EHR Incentive Program. In 2012, Delaware continued to receive A/I/U attestations but concentrated on accepting MU measure attestation and implementing the MAPIR enhancements to receive this information electronically for future stages of MU. From the beginning of the program in 2011, Delaware has continued to collaborate with the DHIN, the REC and other stakeholders to align and evolve the program. The To Be vision is a continually moving target with progress judged by milestones achieved over time. Therefore, the Division will identify the progress made and define further development of the vision in subsequent SMHPs.

## 6..1 Incentive Program's To Be Vision

In the future, it is envisioned that the DHIN will serve as the hub for sharing health information across all EHRs in the State. DHIN will continue to be the primary driver of HIE in Delaware. This includes exchanging measures, clinical data, reportable diseases, and immunizations. As more Medicaid recipient data becomes available, Medicaid analysts will be better able to identify trends and develop interventions aimed at improving resident health outcomes.

As Medicaid looks at interfacing systems and the possibility of freely exchanging data between DMMA, EPs and EHs, the adoption of standards to promote interoperability is critical. DMMA assumes that the ONC and CMS will standardize formats and transactions for reporting MU measures.

All hospitals enrolled and demonstrating meaningful EHR use in Medicare EHR Incentive Program are deemed eligible to enroll in the Medicaid EHR Incentive Program contingent on meeting the Medicaid patient volume requirement. The goal of DMMA is to have 90 percent of all Medicaid recipients' data in an EHR by 2020. The capabilities provided through DHIN will facilitate the attainment of this goal.

**DHIN Functionality Currently Under Development:**

Fraud Detection – DHIN is in the process of piloting a new service called "Health Check Alert" in partnership with the Delaware Division of Medicaid and Medical Assistance. Through this service, subscribing patients receive a text message alert whenever new data is received by DHIN about them, or whenever a user accesses their information in the Community Health Record. Similar to the processes used by credit card companies for fraud alerts, the patient then sends a simple reply indicating whether they do or do not recognize the activity as legitimate. The health plan is then positioned to pursue any potential fraudulent activity

before the claim is paid. Additional benefits to the patient include the knowledge of who is accessing their health data, and awareness of when test results are available, both to the ordering provider and to the patient directly through a patient portal/PHR.

State-wide Patient Portal/Personal Health Record (PHR) – Because DHIN receives data from many sources, we are uniquely positioned to provide patients/consumers with access to their personal health data with minimum effort. For hospitals or practices that have already implemented a patient portal, an API connection to the DHIN data repository allows data from all sources to be retrieved and presented upon patient login to the hospital or practice portal. For those who have not yet implemented a portal, DHIN offers a co-branded implementation of the tool we are calling "Health Check Connect." This not only provides access to the data in the DHIN data repository, but offers additional features and functions, to include secure messaging between providers and patients, patient education resources, and interfaces to various medical devices, such as digital scales, glucometers, blood pressure measuring devices, exercise/activity trackers, and others. The patient will have the option to select their language preference when they set up their account. At launch, supported languages will be English, Spanish and Romanian, with plans to add others as fast as translators can be found to assist with the mapping.

Health Care Claims Database (HCCD)**:** The Delaware General Assembly passed legislation in 2016 authorizing DHIN to stand up a Health Claims Database. Reporting to this database will be required for Medicaid and state employee health plans, qualified health plans on the Marketplace, and federal sources such as Medicare. Other health plans may report data on a voluntary basis. Broad use cases contemplated include support for population health initiatives, provider risk sharing, and consumer shopping. DMMA will explore if the HCCD claims may be used to verify patient volume calculations for the Medicaid EHR Incentive Payment Program. DHIN is in the early stages of planning and implementation. Data collection is projected to begin in March 2018. Funding was included in the SFY 2019 budget to support initial development of the HCCD. Freedman Associates provided technical assistance for the project. DMMA will submit a standardized file layout for Medicaid fee-for-service claims and legacy MCO encounter claims for MCO's who are no longer under contract with DMMA. Several commercial payors in addition to the State Employee Health Plans are also in development to submit claims file layouts.

Medical Orders for End-of-Life Care – the Delaware General Assembly has enacted legislation to establish a common form and accompanying policies and procedures to incorporate patient end-of-life care preferences into a concise set of medical orders (DMOST) which must be honored across the state in all care settings. DHIN is authorized to establish a registry for these orders. We are currently working with the DMOST working group to develop and implement this registry.

**DHIN Functionality – Future Plans**

Mental Health/Behavioral Health Data Exchange – Exchange of mental health data requires more than the usual privacy and security tools. DHIN currently is able to support the granular patient consent that is necessary to restrict viewing of behavioral health data to specific individuals the patient has consented to have such access. Few behavioral health organizations in Delaware currently use electronic health records, but as this number grows, there will be value in including such data in the Community Health Record.

New data types and data sources – The social value of the Community Health Record as well as the value of the DHIN data repository is greatest if all the data are "in" and all the healthcare community is using it. The value can be augmented with the addition of:

- Ambulatory data – DHIN expects to continue a focus on the goal of widespread CCD contributions from the ambulatory setting. Currently, approximately 13% of DE providers contribute such data.
- Claims data – many elements of a claim are useful proxies for clinical information, such as procedure and diagnosis codes, as well as a complete listing of providers seen and medications filled. DHIN has a data use agreement with the dominant carrier in our market, but we have not yet implemented the data feeds.
- Medical device data – EKGs and other devices with output which is graphic or pictorial rather than primarily text or number based, as well as home glucometers and scales would provide very valuable additions to the Community Health Record and enhance care across the care continuum.
- Data from the long term and post-acute care (LTPAC) organizations – These data sources are very important to support the analytics needs of ACOs and providers considering entering into risk-bearing contracts. A small but growing number of LTPAC organizations use electronic health records, but a solid business case to entice them to participate in the information exchange ecosystem has been elusive. DHIN will continue efforts to engage this important group.

Care Gaps: Based on accepted clinical guidelines and using all data from all sources contained in the DHIN repository, DHIN would provide notification of possible gaps in care to enable proactive case management and care coordination.

Risk Stratification**:** Identify high risk patients for special care coordination. This is a necessary activity under some of the newer delivery and payment models, such as Patient Centered Medical Home. The cost of providing this service could be reduced if a single tool and set of risk stratification algorithms is used across the state.

Clinical Quality Measure Reporting**:** Practices may be reporting under multiple programs, such as Meaningful Use, MIPS, and to one or more health plans. DHIN could be the clearing house such that the practice submits all measures once to DHIN, and DHIN reports out to the various end points. DHIN aspires to become a Qualified Clinical Data Registry for this purpose.

DHIN will continue to be the primary driver of HIE in Delaware. This includes exchanging measures, clinical data, reportable diseases, and immunizations. As more Medicaid recipient data becomes available, Medicaid analysts will be better able to identify trends and develop interventions aimed at improving resident health outcomes.

As Medicaid looks at interfacing systems and the possibility of freely exchanging data between DMMA, EPs and EHs, the adoption of standards to promote interoperability is critical. DMMA assumes that the ONC and CMS will standardize formats and transactions for reporting MU measures.

All hospitals enrolled and demonstrating meaningful EHR use in Medicare EHR Incentive Program are deemed eligible to enroll in the Medicaid EHR Incentive Program contingent on

meeting the Medicaid patient volume requirement. The goal of DMMA is to have 90 percent of all Medicaid recipients' data in an EHR by 2020. The capabilities provided through DHIN will facilitate the attainment of this goal.

Delaware EHR Incentive Program began making payments in November 2011 for A/I/U. EPs received payments for MU in October 2012. Table 19 below details the actual and expected participation over time.

**Table 18 Actual and Estimated* Enrollments for EPs & EHs**

| Payment Year | Eligible Professionals | Eligible Hospital | Incentive Payment Year |
|---|---|---|---|
| 2011 | 355 | 7 | 1st year |
| 2012 | 355 | 2 | 2nd year |
| 2013 | 393 | 4 | 3rd year |
| 2014 | 264 | 1 | 4th year |
| 2015 | 349 | 0 | 5th year |
| 2016 | 346 | 0 | 6th year |
| 2017 | 232 | 0 | 7th year |
| 2018* | 250* | 0 | 8th year |
| Total AIU & MU | 2294 | 14 | |

### 6..1.1 SMHP Coordination with MITA Transition

Section 3.2 of this plan described that the greatest and most immediate benefits during the MITA Transition would come from federal project initiatives and mandates whose enhancements would address a number of highly concentrated and recurring themes starting with HIT/SMHP. These themes explain at a high-level the SMHP relationship and coordination with MITA Transition initiatives.

### 6..1.2 Standardize Data Across the Medicaid Enterprise

The Delaware MITA-SSA cited standardization of data across the Medicaid Enterprise as an improvement that would support increased automation and improve data accuracy and enterprise-wide integration of many Delaware Medicaid enterprise business processes. It requires all data and data configurations to be processed at the same level of detail across all DMMA programs and between all contractors and the Medicaid Enterprise. Implementation of MITA standards and interfaces as they become available and other industry standards beyond healthcare information (example: licensing information, financial information) will greatly benefit this initiative. Federally mandated projects such as HIT/SMHP initiatives, HIE development, conversion to International Classification of Diseases, Version 10 (ICD-10), and to 5010 transactions, and the recent Federal Funding for Medicaid Eligibility Determination and Enrollment Activities – (National Proposed Rule Making (NPRM)) all have overlapping requirements to manage and maintain data standards that are in alignment with this theme.

The implementation timeline for this objective is the full 10 years of the MITA SS-A timeline. There is an interim estimate of five years to complete the initial work of establishing national data standards.

### 6..1.3 Availability of Electronic Clinical Data

In the MITA SS-A process, electronic clinical data was often cited as an improvement that would support increased efficiency and make possible improvements in the effective execution of many Delaware Medicaid enterprise business processes. Implementation of ICD-10 code sets furnish much more specific clinical data regarding health conditions and outcomes than is currently available and requirements under ARRA to support the implementation and exchange of EHRs using provider payment incentives have an essential role in attaining this DMMA MITA objective.

The implementation timeline for this priority is estimated at five years and encompasses projects to enhance external interoperability and Medicaid process integration as described in the following subsections.

#### 6..1.3.1 Interoperability to Facilitate External Stakeholder Interaction with Electronic Interfaces

Federal initiatives such as ICD-10 and the EHR Incentive Program will clearly expand the base of core external stakeholders and users of EHR technology and clinical information. MITA cited the expanded implementation of electronic mechanisms to support interactions with and provide information to external Enterprise stakeholders (providers, clients, and contractors) as an improvement that would support increased efficiency and make possible improvements in the effective execution of many Delaware Medicaid enterprise business processes. While some stakeholders welcome the move to electronic mechanisms, it was noted that many are resistant to these changes. Subject Matter Experts (SMEs) cited improved training and incentives to encourage the shift to electronic mechanisms (examples: email, web site/web portal, social media).

Facilitation of interaction with external stakeholders is an ongoing priority. The implementation timeline for this priority is the full 10 years. There is an interim estimate of five years to complete the majority of the improvements cited by SMEs as To Be goals.

#### 6..1.3.2 Integration/Centralization of all Processes Across the Medicaid Enterprise

MITA cited many overlapping processes which had not leveraged the outstanding features of existing systems to improve process maturity. One such example is the processing of treatment plans and service authorizations in different systems within the Enterprise. For federal initiatives such as ICD-10 and the EHR Incentive Program, data sharing architecture must be designed with an acute awareness so as not to duplicate data repositories, systems and interfaces and that integration is ubiquitous for all Enterprise programs and units, to the extent that is feasible.

The implementation timeline to integrate or centralize all functionally similar processes is estimated at five years. This will require the participation and agreement of sister agencies.

There is an interim goal of two years that reflects the fact that some integration can be achieved through review of policy and centralization/integration of some data sources through capabilities already available to the State.

### 6..1.3.3 MMIS Modifications

DMMA is in the process of implementing a new Delaware Medicaid Enterprise System to interface with MAPIR. DMES will also be able to interface with MAPIR. MAPIR has provided a satisfactory means for providers to attest to A/I/U and MU. Customizations were made to MAPIR to work with our system. Below is the schedule for changes and enhancements to MAPIR:

5.0 Stage I changes for Program Year 2013. Implemented April 27, 2013.

5.1 Enhancements to Stage I MU. Reporting changes, button for FQHC/RHC providers to attest. Implemented July 2013.

5.2 Program Year 2014 - Stage I or Stage II MU for Eligible Hospitals. Released by CORE programming group mid November 2013. Implemented January 26, 2014.

5.3 Stage I or Stage II for Eligible Professionals 64 new CQMs and new "domains". Implemented April 2014.

5.4 Enhancements to previous versions. Flexibility Rule changes for Stage II MU for Eligible Hospitals. Implemented November 9, 2014.

5.5 Flexibility Rule Stage II MU changes for Eligible Professionals. Implemented March 9. 2015.

5.6 Enhancements to previous versions. NLR E8 Transactions. Implemented.

5.7 Enhancements & Oracle/Java Sync.

5.8 Enhancement to Meaningful Use for Program Year 2016. Implemented January 9, 2017.

6.0 Enhancements for Meaningful Use for Stage 3. Implemented October 2017.

6.1 Enhancements for Program Year 2017 - 2018 including NLR patches. Implemented June 2018.

6.2 Project schedule creation in progress and will be in Production April 2019.

### 6..1.3.4 Benchmarks and Measures

Another MITA goal is to improve the definition and application of performance measures and methodologies for utilizing results. This applies to both measures articulated as part of contracts and measures to monitor the effectiveness of State responsibilities within and across department/division/unit boundaries. These measures will be expanded to include the MU measures and other measures required to support the Delaware EHR Incentive Program.

The Division of Medicaid and Medical Assistance has updated the Quality Management Strategy (QMS) to incorporate the PROMISE (Promoting Optimal Mental Health for Individuals through Supports and Empowerment) program. The quality strategy plan provides a framework for the State to communicate the vision, objectives, and monitoring strategies for attaining quality, timely access, and cost effectiveness. This effort led to the development of a strategy document, which outlines a series of quality measures. This effort will be expanded upon to include MU measures and other measures to track progress for the Delaware EHR Incentive Program. Once developed, these measures need to be managed to ensure that they continue to meet Enterprise needs. To emphasize this, the implementation timeline for this priority is the full 10 years. There is an interim estimate of five years to complete the initial work of establishing improved and expanded performance and MU criteria and measurements.

On August 27, 2018 Dr. Kara Odom Walker, Secretary, DHSS, submitted a Report to Governor Carney on Establishing a Health Care Benchmark. The Department proposed Quality Measures for Consideration and below is a portion of the report that outlines the Quality Metrics proposed for the first year:

**The Department's Proposed Quality Measures for Consideration**

| Measure | Rationale | Relationship to Advisory Group Suggested Measures |
|---|---|---|
| 1. Ambulatory Care – Sensitive Condition ED Visits | • Improved management of chronic conditions should reduce ED visits and inpatient admissions related to the conditions<br>• Opportunity for improvement:[8]<br>– Commercial rate for ED visits is above the expected level, although below the national average<br>– Medicaid rate for ED visits is not yet publicly available, but will be in the future<br>• Moderate impact and actionable by providers<br>• Potential nearer-term financial impact | Included |
| 2. Two Measures: Opioid-Related Overdose Deaths and Concurrent Use of Opioids and Benzodiazepine | • Addressing opioid use, overdose and mortality is a priority for the State<br>• The overdose death rate measure should be paired with a prescribing measure that is more actionable for insurers and providers<br>• More than 30% of opioid-related deaths nationally involve benzodiazepines[9]<br>• Opportunity for improvement:<br>– Opioid-related overdose death rate is 16th highest in the U.S. and 27% above the national average in the most recent data[10]<br>– Of 16 states participating in enhanced data surveillance, Delaware reported the second-highest percentage change for suspected opioid overdose ED visits, from July 2016 to September 2017[11]<br>– Concurrent use measure: rate not previously calculated for the State<br>• High impact and actionable by providers | Indirect. The Advisory Group suggested the measure Use of Opioids from Multiple Providers, but the Department believes that more opportunity for improvement resides in reducing concurrent opioid and benzodiazepine prescriptions |

In addition to the aforementioned quality measures, the Department recommends a measure related to cardiovascular disease prevention. Heart disease is the second leading cause of death in Delaware after cancer, accounting for 23 percent of all deaths in 2016.[12] There are a number of cardiovascular disease prevention measures available for consideration, including the potential for a composite measure. Due to the importance and technical elements of this issue, the Department recommends that a small stakeholder advisory group be convened temporarily to assist the Department in identifying the most appropriate measure(s), taking into account the selection criteria established by

[8] Source: NCQA Quality Compass Benchmarks for Calendar Year 2016

[9] See www.drugabuse.gov/drugs-abuse/opioids/benzodiazepines-opioids

[10] See www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state/delaware-opioid-summary

[11] See https://news.delaware.gov/2018/03/07/delaware-ed-data-shows-increase-opioid-overdoses/

[12] Newman M. "The top causes of death in Delaware: Cancer leads, but drugs, alcohol numbers rising" *The News Journal* May 15, 2018.

the Advisory Group. The Department recommends that the stakeholder group have members consisting of medical and quality measurement experts. The Department recommends this stakeholder group be convened in late summer or fall of 2018 so that the quality benchmarks can be announced before the end of the year.

### 6..1.4 State Medicaid Agency Role in Provider Incentive Program

DMMA has overall responsibility for the planning and operations of the Delaware EHR Incentive Program. The oversight of payments has four distinct components: determining provider payment eligibility; calculation of payments; making payments; and auditing. These are all current functions of the Medicaid program. The Delaware EHR Incentive Program payments are incorporated into current operations. Most of the day to day program operations are handled by the PIP Team and in operating the MAPIR interface to facilitate program entry, verification of eligibility, attestation, and issuing payments. DMMA's project office, led by the Medicaid HIT Coordinator, directs the implementation of the MAPIR interface within the timeline identified in the IR. DMMA combines State and contractor resources to execute the responsibilities for operations and planning activities.

The DMMA PI supports the investigation of potential fraud and misuse of the Delaware EHR Incentive Program. The Program Integrity Unit will participate in the review of Provider Incentive Payments Program.

## 6..2 State Medicaid Agency Participation in HIE

DMMA actively participates on the DHIN Board of Directors. The two Medicaid MCOs have been receiving Event Notification System (ENS) - Emergency Department Admissions, Discharge and Transfer Notices – from the DHIN since 2013. The DHIN offers certain capabilities that can support Medicaid and EHR Incentive program needs. Some of these capabilities include the following:

- Eligibility Verification
- Directories
- Measuring MU Compliance which includes the following examples:
    - Physicians using a certified EMR
    - Electronic exchange of information

- E-Prescribing and medication history
- CPOE adoption
- Shared MPI

The DHIN Strategic and Operational Plan identifies additional capabilities planned for the network that will further support the Medicaid program and integrate Medicaid data into the exchange network.

**Table 19 Network Functionality Implementation**

- Electronic Clinical Results Delivery
- DHIN-to-EHR Integrations – 27 EHRs; 76% of EHR users in the State
- Community Health Record
- Single Sign-On – connection between DHIN CHR and user's EHR
- Care Summary Creation and Download
- Medication History
- PACS Image Sharing
- Event Notification System – including two Medicaid MCOs.
- Exchange ADTs with the Maryland state HIE, Chesapeake Regional Information System for Our Patients (CRISP)
- Mental Health/Behavioral Health Exchange
- MSD to CCD
- Increase value of the Community Health Record with the addition of ambulatory data, claims data, medical device data.
- DHIN Electronic Public Health Reporting – bio-surveillance and electronic lab reporting; reporting to DelVax, the immunization registry; newborn screening early hearing detection and lab tests for early detection of metabolic and congenital conditions.

As mentioned previously, the SMHP is coordinated with the DHIN Strategic and Operational Plan. Medicaid plays a role in DHIN, but also works cooperatively with other organizations and systems to make exchange efforts successful.

### 6..3 Participation in Statewide, Regional, and/or Local HIE, Initiatives and the NHIN

DMMA works with the State Health Care Commission to coordinate efforts to advance HIT/HIE with other HIE initiatives, contribute to the body of evidence-based practices that emerge through implementation of statewide HIE, and participate in national and interstate efforts to identify and remove barriers to interstate data exchange and connectivity to the eHealthExchange.

DMMA is working collaboratively with other partners to provide capability for interoperability and exchange of health information between EPs, hospitals, FQHCs/RHCs, other Delaware enrolled providers, State and federal agencies responsible for delivery of health care services, and third-party payers throughout Delaware. Health information requests will be transported through the statewide HIE using national standards (i.e., Accredited Standards Committee (ASC) X12; HL7) and share services information to promote care coordination for Medicaid members.

In 2007, DHIN was selected as one of nine HIEs to participate in the Nationwide Health Information Network (NHIN) - (now known as the eHealthExchange). Trial Implementation project led by ONC. As part of the trial implementations, DHIN demonstrated patient preferences, subject discovery, query, retrieval and display of a summary record, lab results distribution, and biosurveillance reporting. DHIN was subsequently awarded an option year contract to continue participation in the eHealthExchange, working toward production connectivity with the National Health Information Exchange (NHIE) Gateway planned to support clinical exchange with the Veteran's Affairs, DoD, and IHS where applicable.

The eHealthExchange will provide a foundation for the health data exchange across diverse entities. Data will include health information reported for public health and safety. DHIN provides the capability for data to flow within and from Delaware local and state entities to national entities as required to meet individual patient needs as well as for the good of the population at large.

## 6..4 Clinical/Meaningful Use Data

Access to clinical EHR data has the potential to greatly expand Medicaid program capabilities. Electronic access to clinical data would allow review of medical record information without paper record submission and simplify the integration of clinical data with administrative and other program information. Possible uses include in-depth quality studies utilizing both administrative (claims) and clinical data; conducting audits, evaluating physician quality issues such as quality of care delivered, care coordination, and prescribing practices; and more real-time predictive modeling data and forecasting.

With this information, DMMA can make focused policy and reimbursement rate decisions based not only on cost information, but also on clinical data that supports quality of services, benefits and outcomes improvement. Statewide policy and funding decisions can be based on comprehensive information and targeted to meet state and national objectives, integrate regional concerns, and be responsive to the needs of all residents. Data-based decisions will be easier to support and better understood by the average consumer, provider, and/or taxpayer.

Access to clinical EHR data also presents enormous opportunities for practitioners to more effectively use their own data as well as state-level aggregate information for comparison to their own practices and patients.

Over time, the widespread adoption of EHRs and utilization of electronic information exchange will provide access to population-based patient specific clinical data. Data at this level can have an infinite variety of uses. While all uses will need to be further investigated for utility, priority, and feasibility, examples of long-term uses of clinical data may include:

- Enhanced utilization review
- Eliminate duplication of services
- Enhance payment record review, both pre and post
- Use of outcomes data for clinical quality and predictive modeling
- QA and performance improvement
- Enhance care coordination
- Evaluate care practices
- In depth provider monitoring, assessment, and accountability

In the MITA SS-A, availability of electronic clinical data was cited as an improvement that would support increased efficiency and make possible improvements in the effective execution of many Delaware Medicaid Enterprise business processes. It is included in the list of mandated priorities because of overlap with the requirements of several federally mandated projects (examples: ICD-10, ARRA).

Clinical Quality Measure Reporting**:** Practices may be reporting under multiple programs, such as Meaningful Use, MIPS, and to one or more health plans. DHIN could be the clearing house such that the practice submits all measures once to DHIN, and DHIN reports out to the various end points. DHIN aspires to become a Qualified Clinical Data Registry for this purpose.

The implementation timeline for this priority is estimated at five years. This is based on:

- Implementation of ICD-10 code sets which furnish much more specific clinical data regarding health conditions and outcomes than is available through current code sets
- Requirements under ARRA to support the implementation and exchange of EHRs using provider pament ince